

# 2025 Kaiser Permanente Dental Benefits and Fee Schedule \$30 Preventive Dental Plan

---

## Dental benefits and fee schedule

### General terms and conditions

Subject to the terms, conditions, limitations, and exclusions specified in this **Evidence of Coverage** including Chapter 12, Definitions of Important Words, you may receive covered dental services from participating dental providers.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. has entered into an agreement with LIBERTY Dental Plan to provide covered dental services through participating dental providers.

## Dental benefits and fee schedule\*

Only the dental procedures listed in the dental fee schedule below are covered dental services. When you receive any of the listed procedures from a participating dental provider, you will pay the fee listed for that service. The participating dental provider has agreed to accept that fee as payment in full for that procedure. Neither Kaiser Permanente nor LIBERTY Dental Plan is liable for payment of these fees or for any fees incurred as the result of receipt of a non-covered dental service.

You may request a list of participating dental providers from LIBERTY Dental Plan, or locate one online at [Libertydentalplan.com/kaiserdentists](http://Libertydentalplan.com/kaiserdentists). You should utilize a participating general dentist from whom you and your family members will receive covered preventive dental services. Family members may use different participating dental providers. Specialty care is also available for certain services should that be required; however, you must be referred to a participating dental provider specialist by your general dentist. Your fees are usually higher for care received by a specialist and not all services are covered. Please refer to the attached dental fee schedule to determine which services are covered when performed by a specialist and the associated fees.

- To find a dentist in your area, you can go to our website at [Libertydentalplan.com/kaiserdentists](http://Libertydentalplan.com/kaiserdentists), download the mobile app on your smart phone, or call us toll-free at **1-888-650-1859** (TTY users call **711**), Monday through Friday from 8 a.m. to 8 p.m. Once you have located a Participating Provider, you can call the office to schedule an appointment. The dental office will contact us to verify your eligibility. Be sure to identify yourself as a Kaiser member when you call the dentist for an appointment. We also suggest that you take this information with you when you go to your appointment. You can then reference benefits and applicable charges which are the out-of-pocket costs associated with your plan.
- The Health Plan has entered into an agreement with LIBERTY Dental Plan Corporation (LIBERTY), to provide Covered Dental Services as described in this agreement. For assistance concerning dental coverage questions or for help finding a Participating Dental Provider, you can go to our website at [Libertydentalplan.com/kaiserdentists](http://Libertydentalplan.com/kaiserdentists), download the mobile app on your smart phone, or call us toll-free **1-888-650-1859** (TTY users call **711**), Monday through Friday from 8 a.m. to 8 p.m.

## Dental emergencies outside the service area

When a dental emergency occurs when you are outside the Service Area from your General Dentist, the Dental Administrator will reimburse the non-participating provider directly. If the member has already paid the charges, the Dental Administrator will reimburse the member (upon proof of payment) instead of paying the provider directly for Covered Dental Services that may have been provided. Reimbursement to the member or provider is not to exceed \$50 per incident. Proof of payment must be submitted to Dental Administrator by provider within one hundred eighty (180) days of treatment. Proof of loss should be mailed to:

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

## Dental benefits and fee schedule\*

LIBERTY Dental Plan  
 Claims Department  
 P.O. Box 26110  
 Santa Ana, CA, 92799-6110

Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. Coverage is limited to those procedures not excluded under Plan limitations and exclusions. You must receive all post-emergency care from your Participating Dental Provider.

Failure to provide proof of loss for a dental emergency, or as may be required under “Non-Participating Specialist Referrals,” within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than one (1) year from the time proof is otherwise required.

### Discounted schedule of fees - \$30 Preventive Plan

You must visit a contracted dental office to utilize covered benefits. For services performed by a Dental Specialist, your dental office will initiate a treatment plan or recommend you see a participating Dental Specialist if the services are medically necessary and outside the scope of general dentistry. You may directly refer to a participating Dental Specialist in the network. For information on locating a Participating Dental Provider, please contact us Toll Free at **1-888-650-1859** (TTY users call **711**), Monday through Friday from 8 a.m. to 8 p.m. Member Copayments for “General Dentist” apply only when performed by a participating general dentist, or a Pediatric Dentist, if needed. Services received from non-participating dentists are not covered under this plan, except for emergency services, out-of-area urgent care, and referrals to non-participating specialists.

Covered Dental Services are limited to the least costly treatment. Dental procedures not listed are available at the dental office’s usual and customary fee. This Schedule does not guarantee benefits. All services are subject to eligibility and dental necessity at the time of service.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
<b>COMBINED FIXED COPAYMENT SERVICES</b>			
Guideline: You pay a combined fixed copayment (FC) \$30 for any visit during which one or more of the following procedures are performed. You pay a separate fee for any other procedure performed.			
D0120	Periodic oral evaluation	<b>FC \$30</b>	<b>Not covered</b>
D0140	Limited oral evaluation - problem focused	<b>FC \$30</b>	<b>Not covered</b>
D0145	Oral evaluation under age 3	<b>FC \$30</b>	<b>Not covered</b>
D0150	Comprehensive oral evaluation	<b>FC \$30</b>	<b>Not covered</b>

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D0170	Re-evaluation - limited, problem focused	FC \$30	Not covered
D0180	Comprehensive periodontal evaluation	FC \$30	Not covered
D0220	Intraoral - periapical first radiographic image	FC \$30	\$15
D0230	Intraoral - periapical each additional radiographic image	FC \$30	\$12
D0240	Intraoral - occlusal radiographic image	FC \$30	\$23
D0250	Extraoral - 2D projection radiographic image, stationary radiation source	FC \$30	\$28
D0270	Bitewing - single radiographic image	FC \$30	\$15
D0272	Bitewings - two radiographic images	FC \$30	\$23
D0273	Bitewings - three radiographic images	FC \$30	\$30
D0274	Bitewings - four radiographic images	FC \$30	\$33
D0277	Vertical bitewings - 7 to 8 radiographic images	FC \$30	\$51
D0340	2D cephalometric radiographic image, measurement and analysis	FC \$30	\$59
D0350	2D oral/facial photographic image, intra-orally/extra-orally	FC \$30	\$31
D0460	Pulp vitality tests	FC \$30	\$38
D0470	Diagnostic casts	FC \$30	Not covered
D0701	Panoramic radiographic image – image capture only	FC \$30	Not covered
D0702	2-D cephalometric radiographic image – image capture only	FC \$30	Not covered
D0703	2-D oral/facial photographic image obtained intra-orally or extra-orally – image capture only	FC \$30	Not covered
D0705	Extra-oral posterior dental radiographic image – image capture only	FC \$30	Not covered
D0706	Intraoral – occlusal radiographic image – image capture only	FC \$30	Not covered
D0707	Intraoral – periapical radiographic image – image capture only	FC \$30	Not covered
D0708	Intraoral – bitewing radiographic image – image capture only	FC \$30	Not covered
D0709	Intraoral – comprehensive series of radiographic images – image capture only	FC \$30	Not covered
D1110	Prophylaxis, adult	FC \$30	Not covered
D1120	Prophylaxis, child	FC \$30	Not covered

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D1206	Topical application of fluoride varnish	FC \$30	Not covered
D1208	Topical application of fluoride, excluding varnish	FC \$30	Not covered
D1310	Nutritional counseling for control of dental disease	FC \$30	Not covered
D1320	Tobacco counseling, control/prevention oral disease	FC \$30	Not covered
D1321	Counseling for the control and prevention of adverse oral, behavioral, and health effects associated with high-risk substance use	FC \$30	Not covered
D1330	Oral hygiene instruction	FC \$30	Not covered
<b>Guideline: You pay an Office Visit copayment when Combined Fixed Copayment services are not performed</b>			
<b><i>Diagnostic Services</i></b>			
	Office visit	\$11	\$12
D0210	Intraoral, comprehensive series of radiographic images	\$58	\$75
D0330	Panoramic radiographic image	\$46	\$59
D0999	Unspecified diagnostic procedure, by report	\$11	\$12
<b><i>Preventive Services</i></b>			
D1110	Prophylaxis, Adult - additional cleaning available for expecting mothers and diabetics	\$40	\$40
D1351	Sealant, per tooth (up to age 16)	\$32	Not covered
D1352	Preventive resin restoration, permanent tooth	\$32	Not covered
D1354	Application of caries arresting medicament, per tooth	\$16	Not covered
D1510	Space maintainer, fixed, unilateral, per quadrant	\$216	Not covered
D1516	Space maintainer, fixed, bilateral, maxillary	\$300	Not covered
D1517	Space maintainer, fixed, bilateral, mandibular	\$300	Not covered
D1520	Space maintainer, removable, unilateral, per quadrant	\$266	Not covered
D1526	Space maintainer, removable, bilateral, maxillary	\$300	Not covered
D1527	Space maintainer, removable, bilateral, mandibular	\$300	Not covered
D1551	Re-cement or re-bond bilateral space maintainer, maxillary	\$25	Not covered
D1552	Re-cement or re-bond bilateral space maintainer, mandibular	\$25	Not covered
D1553	Re-cement or re-bond unilateral space maintainer, per quadrant	\$25	Not covered
D1575	Distal shoe space maintainer, fixed, per quadrant	\$216	Not covered

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay Dentist	Specialist
<b><i>Restorative Services†(Prior authorization is required for Medicare-Covered services only)</i></b>			
D2140	Amalgam - one surface, primary or permanent	<b>\$73</b>	<b>Not covered</b>
D2150	Amalgam - two surfaces, primary or permanent	<b>\$95</b>	<b>Not covered</b>
D2160	Amalgam - three surfaces, primary or permanent	<b>\$113</b>	<b>Not covered</b>
D2161	Amalgam - four or more surfaces, primary or permanent	<b>\$136</b>	<b>Not covered</b>
D2330	Resin-based composite - one surface, anterior	<b>\$90</b>	<b>Not covered</b>
D2331	Resin-based composite - two surfaces, anterior	<b>\$113</b>	<b>Not covered</b>
D2332	Resin-based composite - three surfaces, anterior	<b>\$139</b>	<b>Not covered</b>
D2335	Resin-based composite - four or more surfaces, involving incisal angle	<b>\$176</b>	<b>Not covered</b>
D2390	Resin-based composite crown, anterior	<b>\$233</b>	<b>Not covered</b>
D2391	Resin-based composite - one surface, posterior	<b>\$117</b>	<b>Not covered</b>
D2392	Resin-based composite - two surfaces, posterior	<b>\$154</b>	<b>Not covered</b>
D2393	Resin-based composite - three surfaces, posterior	<b>\$193</b>	<b>Not covered</b>
D2394	Resin-based composite - four or more surfaces, posterior	<b>\$220</b>	<b>Not covered</b>
D2510	Inlay - metallic - one surface	<b>\$532</b>	<b>Not covered</b>
D2520	Inlay - metallic - two surfaces	<b>\$600</b>	<b>Not covered</b>
D2530	Inlay - metallic - three or more surfaces	<b>\$652</b>	<b>Not covered</b>
D2542	Onlay – metallic - two surfaces	<b>\$692</b>	<b>Not covered</b>
D2543	Onlay – metallic - three surfaces	<b>\$705</b>	<b>Not covered</b>
D2544	Onlay – metallic – four or more surfaces	<b>\$710</b>	<b>Not covered</b>
D2610	Inlay - porcelain/ceramic - one surface	<b>\$584</b>	<b>Not covered</b>
D2620	Inlay - porcelain/ceramic - two surfaces	<b>\$622</b>	<b>Not covered</b>
D2630	Inlay - porcelain/ceramic - three or more surfaces	<b>\$718</b>	<b>Not covered</b>
D2642	Onlay - porcelain/ceramic - two surfaces	<b>\$665</b>	<b>Not covered</b>
D2643	Onlay - porcelain/ceramic - three surfaces	<b>\$719</b>	<b>Not covered</b>
D2644	Onlay – porcelain/ceramic - four or more surfaces	<b>\$767</b>	<b>Not covered</b>
D2650	Inlay - resin-based composite - one surface	<b>\$538</b>	<b>Not covered</b>
D2651	Inlay - resin-based composite - two surfaces	<b>\$581</b>	<b>Not covered</b>
D2662	Onlay - resin-based composite - two surfaces	<b>\$613</b>	<b>Not covered</b>
D2663	Onlay - resin-based composite - three surfaces	<b>\$755</b>	<b>Not covered</b>
D2664	Onlay - resin-based composite -four or more surfaces	<b>\$715</b>	<b>Not covered</b>

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D2710	Crown – resin-based composite (indirect)	\$299	Not covered
D2712	Crown 3/4 resin-based composite (indirect)	\$275	Not covered
D2720	Crown - resin with high noble metal	\$729	Not covered
D2721	Crown - resin with predominantly base metal	\$649	Not covered
D2722	Crown - resin with noble metal	\$678	Not covered
D2740	Crown - porcelain/ceramic	\$800	Not covered
D2750	Crown - porcelain fused to high noble metal	\$815	Not covered
D2751	Crown - porcelain fused to predominantly base metal	\$705	Not covered
D2752	Crown - porcelain fused to noble metal	\$733	Not covered
D2753	Crown - porcelain fused to titanium and titanium alloys	\$815	Not covered
D2780	Crown - 3/4 cast high noble metal	\$782	Not covered
D2781	Crown - 3/4 cast predominantly base metal	\$611	Not covered
D2782	Crown - 3/4 cast noble metal	\$660	Not covered
D2783	Crown - 3/4 porcelain/ceramic	\$678	Not covered
D2790	Crown - full cast high noble metal	\$729	Not covered
D2791	Crown - full cast predominantly base metal	\$649	Not covered
D2792	Crown - full cast noble metal	\$678	Not covered
D2794	Crown – titanium and titanium alloys	\$733	Not covered
D2910	Re-cement or re-bond inlay, onlay, veneer, or partial coverage	\$73	Not covered
D2915	Re-cement or re-bond indirectly fabricated/prefabricated post & core	\$40	Not covered
D2920	Recement crown or rebond crown	\$73	Not covered
D2930	Prefabricated stainless steel crown, primary tooth	\$152	Not covered
D2931	Prefabricated stainless steel crown, permanent tooth	\$201	Not covered
D2932	Prefabricated resin crown	\$274	Not covered
D2934	Prefabricated esthetic coated stainless steel crown, primary tooth	\$118	Not covered
D2940	Protective restoration	\$83	Not covered
D2941	Interim therapeutic restoration, primary dentition	\$53	Not covered
D2950	Core buildup, including any pins when required	\$183	Not covered
D2951	Pin retention - per tooth, in addition to restoration	\$43	Not covered
D2952	Post and core in addition to crown, indirectly fabricated	\$272	Not covered

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D2954	Prefabricated post and core in addition to crown	\$242	Not covered
D2955	Post removal	\$210	Not covered
D2980	Crown repair necessitated by restorative material failure	\$149	Not covered
D2981	Inlay repair necessitated by restorative material failure	\$149	Not covered
D2982	Onlay repair necessitated by restorative material failure	\$149	Not covered
<b><i>Endodontic Services† (Prior authorization is required for Medicare-Covered services only)</i></b>			
D3110	Pulp cap - direct (excluding final restoration)	\$51	Not covered
D3120	Pulp cap - indirect (excluding final restoration)	\$51	Not covered
D3220	Therapeutic pulpotomy (excluding final restoration)	\$112	\$132
D3221	Pulpal debridement, prim. and perm. teeth	\$136	Not covered
D3222	Partial pulpotomy, apexogenesis, permanent tooth, incomplete root	\$123	Not covered
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	\$123	Not covered
D3240	Pulpal therapy, posterior, primary tooth (excluding finale restoration)	\$211	Not covered
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$521	\$598
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	\$622	\$716
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$815	\$936
D3333	Internal root repair of perforation defects	Not covered	\$243
D3346	Retreatment of previous root canal therapy - anterior	Not covered	\$658
D3347	Retreatment of previous root canal therapy - premolar	Not covered	\$877
D3348	Retreatment of previous root canal therapy - molar	Not covered	\$1131
D3351	Apexification/recalcification, initial visit	\$413	\$486
D3352	Apexification/recalcification, interim medication replacement	\$323	\$382
D3353	Apexification/recalcification, final visit	\$354	\$418
D3410	Apicoectomy - anterior	\$456	\$566
D3421	Apicoectomy- premolar (first root)	\$509	\$707

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.



ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D3425	Apicoectomy - molar (first root)	\$559	\$742
D3426	Apicoectomy (each additional root)	\$339	\$401
D3430	Retrograde filling - per root	\$127	\$319
D3450	Root amputation - per root	\$221	\$356
D3471	Surgical repair of root resorption - anterior	\$456	\$566
D3472	Surgical repair of root resorption – premolar	\$509	\$707
D3473	Surgical repair of root resorption – molar	\$559	\$742
D3501	Surgical exposure of root surface without apicoectomy or repair of root resorption – anterior	\$456	\$566
D3502	Surgical exposure of root surface without apicoectomy or repair of root resorption – premolar	\$509	\$707
D3503	Surgical exposure of root surface without apicoectomy or repair of root resorption – molar	\$559	\$742
D3920	Hemisection not including root canal therapy	\$279	\$329
D3921	Decoronation or submergence of an erupted tooth	\$100	\$125
D3950	Canal prep/fitting of preformed dowel or post	\$166	\$233
<b><i>Periodontic Services† (Prior authorization is required for Medicare-Covered services only)</i></b>			
D4210	Gingivectomy or gingivoplasty - four or more teeth per quadrant	\$402	\$474
D4211	Gingivectomy or gingivoplasty - one to three teeth, per quadrant	\$174	\$205
D4230	Anatomical crown exposure, four or more contiguous teeth per quadrant	\$497	<b>Not covered</b>
D4231	Anatomical crown exposure, one to three teeth per quadrant	\$66	<b>Not covered</b>
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth	\$517	\$611
D4241	Gingival flap procedure, including root planing - one to three teeth, per quadrant	\$131	\$258
D4249	Clinical crown lengthening, hard tissue	\$543	\$642
D4260	Osseous surgery, four or more teeth per quadrant	\$766	\$903
D4261	Osseous surgery, one to three teeth per quadrant	\$488	\$577

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D4263	Bone replacement graft, retained natural tooth, first site, quadrant	\$217	\$445
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	\$183	\$222
D4268	Surgical revision procedure, per tooth	\$420	\$607
D4270	Pedicle soft tissue graft procedure	\$577	\$680
D4274	Mesial/distal wedge procedure, single tooth	\$355	\$503
D4275	Non-autogenous connective tissue graft, first tooth	\$306	\$689
D4276	Combined connective tissue and pedicle graft	\$368	\$567
D4322	Splint, intra-coronal; natural teeth or prosthetic crowns	\$285	\$337
D4323	Splint, extra-coronal; natural teeth or prosthetic crowns	\$216	\$254
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$148	\$210
D4342	Periodontal scaling and root planing - one to three teeth, per quadrant	\$107	\$126
D4346	Scaling in presence of moderate or severe inflammation, full mouth after evaluation	\$82	\$111
D4355	Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis, subsequent visit	\$131	\$189
D4381	Localized delivery of antimicrobial agents	\$36	\$48
D4910	Periodontal maintenance	\$90	\$119
<b><i>Prosthetics - Removable† (Prior authorization is required for Medicare-Covered services only)</i></b>			
D5110	Complete denture - maxillary	\$913	Not covered
D5120	Complete denture - mandibular	\$913	Not covered
D5130	Immediate denture - maxillary	\$983	Not covered
D5140	Immediate denture - mandibular	\$983	Not covered
D5211	Maxillary partial denture - resin base	\$705	Not covered
D5212	Mandibular partial denture - resin base	\$705	Not covered
D5213	Maxillary partial denture, cast metal, resin base	\$978	Not covered

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D5214	Mandibular partial denture, cast metal, resin base	\$978	Not covered
D5221	Immediate maxillary partial denture, resin base	\$705	Not covered
D5222	Immediate mandibular partial denture, resin base	\$705	Not covered
D5223	Immediate maxillary partial denture, cast metal framework, resin denture base	\$978	Not covered
D5224	Immediate mandibular partial denture, cast metal framework, resin denture base	\$978	Not covered
D5225	Maxillary partial denture, flexible base	\$976	Not covered
D5226	Mandibular partial denture, flexible base	\$1084	Not covered
D5227	Immediate maxillary partial denture, flexible base	\$976	Not covered
D5228	Immediate mandibular partial denture, flexible base	\$1084	Not covered
D5282	Removable unilateral partial denture - one piece cast metal, maxillary	\$551	Not covered
D5283	Removable unilateral partial denture - one piece cast metal, mandibular	\$551	Not covered
D5284	Removable unilateral partial denture – one piece flexible base, per quadrant	\$551	Not covered
D5286	Removable unilateral partial denture – one piece resin (including clasps and teeth) – per quadrant	\$551	Not covered
D5410	Adjust complete denture - maxillary	\$85	Not covered
D5411	Adjust complete denture - mandibular	\$85	Not covered
D5421	Adjust partial denture - maxillary	\$85	Not covered
D5422	Adjust partial denture - mandibular	\$85	Not covered
D5511	Repair broken complete denture base - mandibular	\$109	Not covered
D5512	Repair broken complete denture base - maxillary	\$109	Not covered
D5520	Replace missing or broken teeth - complete denture	\$83	Not covered
D5611	Repair resin denture base - mandibular	\$110	Not covered
D5612	Repair resin denture base - maxillary	\$110	Not covered
D5621	Repair cast partial framework - mandibular	\$159	Not covered
D5622	Repair cast partial framework - maxillary	\$159	Not covered
D5630	Repair or replace broken retentive/clasping material – per tooth	\$150	Not covered

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D5640	Replace broken teeth - per tooth	\$95	Not covered
D5650	Add tooth to existing partial denture	\$141	Not covered
D5660	Add clasp to existing partial denture – per tooth	\$173	Not covered
D5670	Replace all teeth & acrylic on cast metal frame, maxillary	\$604	Not covered
D5671	Replace all teeth & acrylic on cast metal frame, mandibular	\$604	Not covered
D5710	Rebase complete maxillary denture	\$372	Not covered
D5711	Rebase complete mandibular denture	\$357	Not covered
D5720	Rebase maxillary partial denture	\$286	Not covered
D5721	Rebase mandibular partial denture	\$286	Not covered
D5725	Rebase hybrid prosthesis	\$372	Not covered
D5730	Reline complete maxillary denture (direct)	\$231	Not covered
D5731	Reline complete mandibular denture (direct)	\$232	Not covered
D5740	Reline maxillary partial denture (direct)	\$229	Not covered
D5741	Reline mandibular partial denture (direct)	\$229	Not covered
D5750	Reline complete maxillary denture (indirect)	\$281	Not covered
D5751	Reline complete mandibular denture (indirect)	\$279	Not covered
D5760	Reline maxillary partial denture (indirect)	\$270	Not covered
D5761	Reline mandibular partial denture (indirect)	\$269	Not covered
D5765	Soft liner for complete or partial removable denture – indirect	\$50	Not covered
D5810	Interim complete denture (maxillary)	\$593	Not covered
D5811	Interim complete denture (mandibular)	\$432	Not covered
D5820	Interim partial denture, maxillary	\$458	Not covered
D5821	Interim partial denture, mandibular	\$463	Not covered
D5850	Tissue conditioning, maxillary	\$130	Not covered
D5851	Tissue conditioning, mandibular	\$131	Not covered
<b><i>Prosthodontics - Fixed† (Prior authorization is required for Medicare-Covered services only)</i></b>			
D6092	Re-cement or re-bond implant/abutment supported crown	\$75	Not covered
D6093	Re-cement or re-bond implant/abutment supported FPD	\$112	Not covered
D6205	Pontic, indirect resin based composite	\$276	No covered
D6210	Pontic - cast high noble metal	\$659	Not covered
D6211	Pontic - cast predominantly base metal	\$674	Not covered

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D6212	Pontic - cast noble metal	\$633	Not covered
D6214	Pontic – titanium and titanium alloys	\$617	Not covered
D6240	Pontic - porcelain fused to high noble metal	\$815	Not covered
D6241	Pontic - porcelain fused to predominantly base metal	\$705	Not covered
D6242	Pontic - porcelain fused to noble metal	\$733	Not covered
D6243	Pontic - porcelain fused to titanium and titanium alloys	\$617	Not covered
D6245	Pontic – porcelain/ceramic	\$800	Not covered
D6250	Pontic - resin with high noble metal	\$805	Not covered
D6251	Pontic - resin with predominantly base metal	\$764	Not covered
D6252	Pontic - resin with noble metal	\$774	Not covered
D6545	Retainer - cast metal for resin bonded fixed prosthesis	\$292	Not covered
D6548	Retainer. - porcelain/ceramic for resin bonded fixed prosthesis	\$519	Not covered
D6549	Resin retainer – for resin bonded fixed prosthesis	\$292	Not covered
D6600	Retainer inlay - porcelain/ceramic, two surfaces	\$432	Not covered
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	\$460	Not covered
D6602	Retainer inlay - cast high noble metal, two surfaces	\$456	Not covered
D6603	Retainer inlay - cast high noble metal, three or more surfaces	\$505	Not covered
D6604	Retainer inlay, cast base metal, two surfaces	\$456	Not covered
D6605	Retainer inlay, cast base metal, three or more surfaces	\$436	Not covered
D6606	Retainer inlay - cast noble metal, two surfaces	\$415	Not covered
D6607	Retainer inlay - cast noble metal, three or more surfaces	\$460	Not covered
D6608	Retainer onlay -porcelain/ceramic, two surfaces	\$472	Not covered
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	\$495	Not covered
D6610	Retainer onlay - cast high noble metal, two surfaces	\$541	Not covered
D6611	Retainer onlay cast high noble metal, three or more surfaces	\$592	Not covered
D6612	Retainer onlay - cast predominantly base metal, two surfaces	\$465	Not covered
D6613	Retainer onlay - cast base metal, three or more surfaces	\$516	Not covered
D6614	Retainer onlay - cast noble metal, two surfaces	\$490	Not covered
D6615	Retainer onlay cast noble metal, three or more surfaces	\$541	Not covered
D6624	Retainer inlay - titanium	\$505	Not covered

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D6634	Retainer onlay - titanium	\$592	Not covered
D6710	Retainer crown, indirect resin based composite	\$276	
D6720	Retainer crown - resin with high noble metal	\$807	Not covered
D6721	Retainer crown - resin with predominantly base metal	\$719	Not covered
D6722	Retainer crown - resin with noble metal	\$752	Not covered
D6740	Retainer crown – porcelain/ceramic	\$800	Not covered
D6750	Retainer crown - porcelain fused to high noble metal	\$690	Not covered
D6751	Retainer crown - porcelain fused to predominantly base metal	\$617	Not covered
D6752	Retainer crown - porcelain fused to noble metal	\$647	Not covered
D6753	Retainer crown - porcelain fused to titanium and titanium alloys	\$733	Not covered
D6780	Retainer crown - 3/4 cast high noble metal	\$782	Not covered
D6781	Retainer crown - 3/4 cast predominantly base metal	\$611	Not covered
D6782	Retainer crown - 3/4 cast noble metal	\$624	Not covered
D6783	Retainer crown - 3/4 porcelain/ceramic	\$873	Not covered
D6784	Retainer crown - 3/4 titanium and titanium alloys	\$733	Not covered
D6790	Retainer crown - full cast high noble metal	\$729	Not covered
D6791	Retainer crown - full cast predominantly base metal	\$649	Not covered
D6792	Retainer crown - full cast noble metal	\$678	Not covered
D6794	Retainer crown – titanium and titanium alloys	\$733	Not covered
D6930	Recement or re-bond fixed partial denture	\$95	Not covered
D6940	Stress breaker	\$221	Not covered
D6980	Fixed partial denture repair, restorative material failure	\$222	Not covered
<b><i>Oral and Maxillofacial Surgery†(Prior authorization is required for Medicare-Covered services only)</i></b>			
D7111	Extraction, coronal remnants - primary tooth	\$78	\$92
D7140	Extraction, erupted tooth or exposed root	\$90	\$105
D7210	Extraction of erupted tooth requiring removal of bone and/or sectioning of tooth	\$161	\$190
D7220	Removal of impacted tooth - soft tissue	\$198	\$233
D7230	Removal of impacted tooth - partially bony	\$270	\$319
D7240	Removal of impacted tooth - completely bony	\$319	\$375

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D7241	Removal of impacted tooth - completely bony, complication	\$392	\$463
D7250	Removal of residual tooth roots (cutting procedure)	\$180	\$215
D7251	Coronectomy - intentional partial tooth removal	\$392	\$463
D7260	Oroantral fistula closure	\$487	\$575
D7261	Primary closure of a sinus perforation	\$200	\$575
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$301	\$356
D7280	Exposure of an unerupted tooth	\$337	\$399
D7282	Mobilization of erupted/malpositioned tooth	\$104	\$227
D7283	Placement, device to facilitate eruption, impaction	\$73	\$140
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$212	\$249
D7286	Biopsy of oral tissue - soft (all others)	\$199	\$233
D7287	Exfoliative cytological sample collection	\$43	\$76
D7288	Brush biopsy, transepithelial sample collection	\$43	\$76
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$153	\$183
D7292	Surgical placement: temporary anchorage device (screw retained Plate) requiring flap	\$1210	Not covered
D7293	Surgical placement: temporary anchorage device requiring flap	\$967	Not covered
D7294	Surgical placement: temporary anchorage device without flap	\$726	Not covered
D7310	Alveoloplasty in conjunction with extractions - per quadrant	\$162	\$191
D7311	Alveoloplasty in conjunction with extractions	\$140	\$166
D7320	Alveoloplasty not in conjunction with extractions – per quadrant	\$208	\$245
D7321	Alveoloplasty not in conjunction with extractions	\$43	\$91
D7410	Excision of benign lesion up to 1.25 cm	\$203	\$241
D7411	Excision of benign lesion greater than 1.25 cm	\$200	\$234
D7412	Excision of benign lesion, complicated	\$278	\$326
D7450	Removal of benign odontogenic cyst/tumor up to 1.25cm	\$284	\$334

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D7451	Removal of benign odontogenic cyst/tumor greater than 1.25cm	\$357	\$422
D7460	Removal of benign nonodontogenic cyst/tumor up to 1.25cm	\$273	\$321
D7461	Removal of benign nonodontogenic cyst/tumor greater than 1.25cm	\$386	\$456
D7471	Removal of lateral exostosis	\$339	\$400
D7472	Removal of torus palatinus	\$284	\$336
D7473	Removal of torus mandibularis	\$293	\$346
D7485	Reduction of osseous tuberosity	\$321	\$379
D7510	Incision and drainage of abscess - intraoral soft tissue	\$117	\$137
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	\$244	\$281
D7520	Incision & drainage of abscess, extraoral soft tissue	\$244	\$287
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	\$170	\$195
D7530	Remove foreign body, mucosa, skin, tissue	\$170	\$201
D7550	Partial ostect/sequestrect non-vital bone removal	\$284	\$337
D7910	Suture of recent small wounds up to 5 cm	\$266	\$313
D7911	Complicated suture, up to 5 cm	\$219	\$259
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	\$25	\$25
D7961	Buccal/labial frenectomy (frenulectomy)	\$287	\$339
D7962	Lingual frenectomy (frenulectomy)	\$287	\$339
D7963	Frenuloplasty	\$107	\$265
D7970	Excision of hyperplastic tissue - per arch	\$492	\$582
D7971	Excision of pericoronal gingiva	\$243	\$286
D7972	Surgical reduction of fibrous tuberosity	\$84	\$200
D7979	Non-surgical sialolithotomy	\$32	\$81
<b>Orthodontics† (Prior authorization is required for Medicare-Covered services only)</b>			
D8070	Comprehensive orthodontic treatment of the transitional dentition	Not covered	\$3,990

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.



ADA Code	Description of Services	*What you must pay	
		Dentist	Specialist
D8080	Comprehensive orthodontic treatment of the adolescent dentition	Not covered	\$4,132
D8090	Comprehensive orthodontic treatment of the adult dentition	Not covered	\$4,417
D8660	Pre-orthodontic treatment examination to monitor growth and development	Not covered	\$499
D8670	Periodic orthodontic treatment visit (as part of contract)	Not covered	\$142
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	Not covered	\$516
<b><i>Adjunctive General Services† (Prior authorization is required for Medicare-Covered services only)</i></b>			
D9110	Palliative treatment of dental pain, per visit	\$32	\$81
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$0	Not covered
D9211	Regional block anesthesia	\$0	Not covered
D9212	Trigeminal division block anesthesia	\$0	Not covered
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$0	Not covered
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	\$0	Not covered
D9222	Deep sedation/general anesthesia, first 15 minute increment	\$66	\$147
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	\$66	\$147
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$39	\$44
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	\$66	\$147
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	\$66	\$147
D9310	Consultation, other than requesting dentist	\$64	\$104
D9440	Office visit, after regularly scheduled hours	\$29	\$120
D9613	Infiltration of sustained release therapeutic drug, per quadrant	\$205	\$205
D9910	Application of desensitizing medicament	\$32	\$65
D9930	Treatment of complications, post surgical, unusual circumstances, by report	\$52	\$52

†Your provider must obtain prior authorization from our plan.

\* Your cost-sharing for these services or items doesn't apply toward the out-of-pocket maximum.

---

<b>ADA Code</b>	<b>Description of Services</b>	<b>*What you must pay</b>	
		<b>Dentist</b>	<b>Specialist</b>
D9942	Repair and/or relines of occlusal guard	<b>\$57</b>	<b>\$109</b>
D9944	Occlusal guard – hard appliance, full arch	<b>\$365</b>	<b>\$561</b>
D9945	Occlusal guard – soft appliance, full arch	<b>\$365</b>	<b>\$561</b>
D9946	Occlusal guard – hard appliance, partial arch	<b>\$365</b>	<b>\$561</b>
D9950	Occlusion analysis - mounted case	<b>\$183</b>	<b>\$183</b>
D9951	Occlusal adjustment - limited	<b>\$95</b>	<b>\$124</b>
D9952	Occlusal adjustment - complete	<b>\$402</b>	<b>\$645</b>
D9986	Missed appointment	<b>\$50</b>	<b>\$50</b>
D9995	Teledentistry – synchronous; real-time encounter	<b>\$0</b>	<b>\$0</b>
D9996	Teledentistry – asynchronous; information stored and forwarded to dentist for subsequent review	<b>\$0</b>	<b>\$0</b>
D9997	Dental case management – patients with special health care needs	<b>\$50</b>	<b>\$50</b>

---