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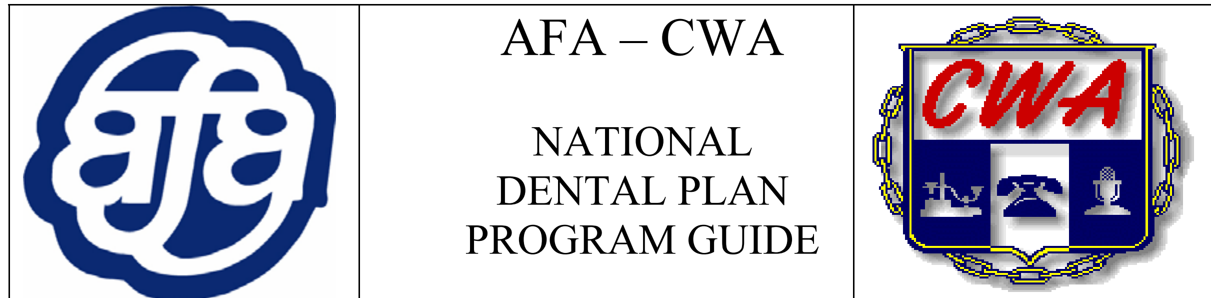

AFA – CWA

NATIONAL DENTAL PLAN PROGRAM GUIDE

ASSOCIATION OF FLIGHT ATTENDANTS – COMMUNICATIONS WORKERS OF AMERICA
501 THIRD STREET NW
WASHINGTON, DC 20001
TEL: 202-434-1300

2007

AFA - CWA DENTAL PROGRAM OUTLINE

DENTISTRY FOR YOU AND YOUR FAMILY

Union Dental Corp. and your Association of Flight Attendants union leaders have signed an agreement to provide a network of dentists utilizing insurance supplied to you by your employer. **THIS NETWORK IS NOT A SECONDARY DENTAL INSURANCE. All dental claims are processed through the airlines' dental insurance company.**

HOW DO YOU BENEFIT BY USING UNION DENTAL PROVIDERS? The Usual, Customary and Reasonable (UCR) fee for a Crown (code 2750) is $925. The dentists in the UDC network will only charge you $618. Your payment responsibility is the difference between the insurance reimbursement and the $618. If the dentist you select is in the PDP network of providers for your insurance provider, then the cost of the Crown is even less and you will save more. In addition to those savings, you can use the coupons in this brochure and save even more money. When you have used your maximum benefits in a given year, our dentists will only charge you the $618 for the crown and NOT the UCR of $925. This formula is used for all procedures performed.

Another example would be the UCR for a root canal (code 3330) which is $975. The dentist in the UDC network would only charge $646. If the dentist you select is in the PDP network of providers for your insurance provider, then the cost of the Root Canal is even less and you will save more. In addition to those savings, you can use the coupons in this brochure and save even more money. When you have used your maximum benefits in a given year, our dentists will only charge you the $646 for the crown and NOT the UCR of $925. Any procedure will be performed at a savings to you by benefit of your union membership.

AFA Members may use any provider in any state at anytime and receive the same benefits. This may be beneficial to extended families or dependents away at college. Uninsured and extended family members may also take advantage of this program, its benefits and the coupons offered because you are an AFA member.

Visit the website for the Complete AFA Program Outline and all of the fee costs (by code) for dental procedures.

OUT-OF-POCKET RESPONSIBILITY. You will be responsible for the difference between the insurance reimbursement and the cost of the discounted dental procedure which you can view in the Fee Schedule under your dental plan with the Company. These low out-of-pocket payments are estimated at the initial consultation. This initial consultation is provided by the dentist at no charge to you. X-Rays or services provided are NOT included in the consultation. Make sure you have the dentist prepare a treatment plan so you know what your out-of-pocket expenses are before you have any dental work done.

RETIREES OR NO INSURANCE COVERAGE: The Union Dental network of dentists will charge you only the fees in the Program Outline (see www.afadental.com) for the procedures outlined because you are an AFA member or retired member. These savings are a significant

discount (sometimes more than 25%) from Usual, Customary and Reasonable (UCR) fees charged at their dental offices.

DHMO SUBSCRIBERS – Our Union Dental/Smilecare Dental offices in California and Nevada will accept your insurance at any of their locations. Just Contact your plan administrator and select Smilecare. American Dental Centers in OH will accept your insurance. Contact your plan administrator.

AIR TRAN - Insurance provider is United Healthcare Services. They have a $50 deductible for employee and $150 deductible for family. Most preventive procedures are covered 100% and all other work is 50%.

AIR WISCONSIN – Insurance provider is Humana Dental. They have a $25 deductible for employee and $75 deductible for family. Preventative, Basic and Major procedures are covered at 80%. The annual maximum is $1250 per person. Additional lifetime Orthodontia coverage is $1,500 per person.

ALOHA – Benefit package insurance carrier is Delta Dental – Hawaii Dental Service. Preventative is covered at 100% and most other services are covered at 75%. Please refer to your Dental Plan Summary for maximum yearly allowable amount. Orthodontia for Flight Attendants and dependents through age 18 or 23 (full time students) covered at 60% with a lifetime maximum of $1500.

ATA - Insurance carrier is Met Life. There is a $50 deductible for employee and $150 deductible for family. Most preventive procedures are covered 100% and all other work is 50%. Annual maximum is $1,000 per person. Additional lifetime Orthodontia coverage of $1,500 per person.

ALASKA AIRLINES -Insurance carrier is Aetna. $25 deductible individual and $50 deductible for family. There is a separate $100 deductible for orthodontia. Yearly maximum benefit $1,500 per person. There is a $2,000 lifetime orthodontia maximum benefit. The Plan pays 80% of covered charges for allowed procedures for both dental and orthodontic work.

AMERICAN EAGLE – Insurance carrier is Met Life. There is a $50 annual deductible per person. The annual maximum benefit is $1,000 per person. Preventative services are covered at 80%. Basic, Major and Orthodontia Services are covered at 50%. There is an additional $1,500 Maximum Lifetime benefit per dependent child for Orthodontia.

AMERICA WEST - Insurance carrier is MetLife. There are two levels of coverage; high option and low option. High Option: In-network and out-of-network are essentially the same. Both have deductibles of $50 for Preventive services and $150 for Basic and Major services. Preventive services are covered at 100%. Basic services are covered at 80% (70% out-of-network). Major services are covered at 50%. Annual benefit maximum is $1,000 per person. Orthodontia lifetime maximum is $1,000 per person.

Low Option: In-network: No deductible. Preventive services are covered at 100%; Basic services are covered at 50%; and Major services are covered at 30%. 35% coverage for orthodontia. $1,000 per person annual maximum. $1,000 per person lifetime maximum for orthodontia. Out-of-network: Deductibles of $100/300 (indiv./family). Preventive services are covered at 70%; Basic services are covered at 40% and Major services are covered at 20%. 20%

coverage for orthodontia. $500 per person annual maximum. $500 per person lifetime maximum.

ATLANTIC SOUTHEAST – At printing this information was not available. Please check the website www.afadental.com for updated information.

HAWAIIAN - Benefit package insurance carrier is Delta Dental. PPO Plan with 100% coverage of preventive services. Most other services covered at 70% (Prosthodontics at 50%). No annual benefit maximum. Orthodontia for Flight Attendants and dependents through age 18 or 22. Covered at 60% with a lifetime maximum of $1,500.

HORIZON -Insurance carrier is United Health Group. There is a deductible of $50/individual. The deductible applies to all services except Preventive and Major Care. Preventive care is paid at 100%, Basic at 80%, and Major at 50%. Calendar maximum benefit is $2,000. Note: Orthodontia is not described in the listed services.

MESA -Insurance carrier is First Health Dental Guard. Mesa has two programs. One is a PPO and the other is the Non-PPO. PPO annual deductibles are $50/individual and $150/family. The PPO annual maximum benefit is $1,500 per individual. The Non-PPO deductibles are$100/individual and $200/family. The Non-PPO annual maximum benefit is $1,000 per individual. Orthodontia dependents to age 19 years only) benefit limits are $2,000 in the PPO and $1,500 in the Non-PPO program.
Services and % coverage for PPO and Non-PPO are as follows:

Preventive	100%	80%
Basic	80%	60%
Major	50%	50%
Orthodontic	50%	40%

MESABA - Insurance carrier is United Health Group. There is a two tier plan. Level 1 covers full time employees after 90 days of service or part-time employees who have 2 years of service or 2000 hours. Level II benefits are available for employees who have been covered under level I for at least 12 months. The higher benefit becomes effective the following January 1. Level I benefits include: $75 deductible for preventive services. There is a $150 deductible for Basic, Major restorative, Prosthodontic, and Orthodontic expenses; 100% coverage of preventive services; 70% (after deductible) for Basic services; 50% (after deductible) for Prosthodontic services; Major restorative and Orthodontia is NOT covered. There is a $500 calendar year maximum benefit. Level II benefits include: $25 deductible for preventive services. There is a $50 deductible for Basic; Major restorative, Prosthodontic, and Orthodontic expenses. There is 100% coverage of preventive services; 80% (after deductible) for Basic services and Major restorative; 50% (after deductible) for Prosthodontic services and Orthodontia. There is a $1000 calendar year maximum benefit.

MIAMI AIR – Dental coverage is through the DeltaCare Program, a combination pre-paid, fee for service benefit. No annual dollar maximum except for accidental injury. Orthodontic benefits cover 24 months of active comprehensive orthodontic treatment. Please see your certificate of coverage for complete information.

MIDWEST - Benefit package insurance carrier is Delta Dental. Midwest has a Gold PPO Plan and a Silver PPO Plan with different levels of benefits and deductibles for in and out of network.

Gold PPO In-network	Gold PPO Out-of-network
No deductibles in-network	$50/individual and $150/family

deductible waived for preventive	Not waived
$1,500 maximum benefit	$1,500 maximum benefit
Preventive coverage 100%	Preventive coverage 80%
Basic restorative services 90%	Basic restorative services 60%
Major restorative services 50%	Major restorative services 50%
Orthodontia 60%	Orthodontia 60%
lifetime max. $2000	Lifetime max. $1,500

Silver PPO In-network	Silver PPO Out-of-Network
$25/individual; $75/family	$50/individual and $150/family
deductible waived for preventive	Not waived
$1,200 maximum benefit	$1,200 maximum benefit
Preventive coverage 100%	Preventive coverage 70%
Basic restorative services 80%	Basic restorative services 50%
Major restorative services 50%	Major restorative services 50%
Orthodontia 50%	Orthodontia 50%
lifetime max. $1,500	Lifetime max. $1,200

NORTHWEST - Insurance is administered by Delta Dental. There is a calendar year deductible of $50/individual and $125/family. Covers two fluoride treatments (under 19 years of age) per year; two cleanings per year; and two routine oral exams each year. There is a $2,000 annual benefit for Class I (preventive) covers 90%; Class II (minor restorative) 80% after deductible; & Class III (major Restorative, including implants as long as it is not for cosmetic reasons) 60% after deductible. There is a $2,000 lifetime benefit for Class IV (Orthodontia) 50%.

PIEDMONT – The Dental Plan for Piedmont has a $1,000 per person annual maximum. Preventative is covered at 100% with no deductible. Basic is covered at 85% with a $50 deductible. Major is covered at 50% with a $50 deductible. Orthodontia is available only to dependent children. The lifetime maximum is $1000 per child with a $50 deductible.

PSA - Insurance carrier is Anthem BlueCross/BlueShield. There is an annual deductible of $100/person and $300/family. Certain preventive services are not subject to the deductible and are covered 100%. These include 2 oral examinations per year, bite-wing x-rays, two cleaning per year, topical fluoride, space maintenance, and emergency treatment for pain. Other services are covered at either 85% or 60% after payment of the deductible. Orthodontia is covered at 60% for both children and adults. There is a lifetime maximum benefit of $1,500 per covered person. There is a yearly maximum benefit of $1,500 per person.

SPIRIT - Insurance carrier is Aetna. Spirit has a DMO. The DMO schedule provides a list of services and procedures for which a patient pays amount specified. There are no charges for diagnostic and most preventive services. There is a yearly deductible of $50/individual and $150/family. The deductible applies to Basic and Major services only. Preventive services are paid at 100%, Basic services at 80%, and Major services at 50%. The annual maximum benefit for dental services is $1,000. Major restorative services have a lifetime maximum of $1,000. The comprehensive charge for orthodontia is $1,545 (both children and adults). There are separate fees for the screening exam, diagnostic records, and retention.

UNITED - Insurance carrier is MetLife. There is a traditional dental plan and a dental HMO (DMO). Traditional Plan: Deductibles of $50/individual and $100/family. There is coverage of 100/80/50 for preventive, basic, and major services; 50% coverage for Orthodontia. The annual maximum benefit per person is $2,000. The lifetime maximum per person is $2,000 DMO: No deductible. No annual maximum for Aetna DMO and $2,000 for Dental Network. There is

100% coverage for preventive and basic services; Various rates (70-75%) and co-payments for other services, depending on plan.

US AIRWAYS -Insurance carrier is MetLife. There is no deductibles in-network. There is a $50/individual; $100/ family deductible out-of-network. Coverage includes 100% preventative; 80% minor; 50% major. There is a yearly maximum benefit of $1,500 per person in-network; $1,000 out-of-network. There is Orthodontia coverage in-network 50% of discounted fee; out-of-network 50% of usual and customary charge. Not subject to annual maximum but is subject to $2,000 lifetime maximum benefit. This $2,000 includes network and non-network charges.

AFA - CWA Dental Fee Schedule

Code	Description of Procedure	Total
O120	Periodic oral exam	$44.00
O150	Comp. oral exam	$82.00
O210	Comp. full mouth xray	$68.00
O220	Intraoral periapical (1st film)	$22.00
O230	Intraoral periapical (each add'l film)	$17.00
O270	Bitewing-single film	$12.00
O272	Bitewings-two films	$19.00
O274	Bitewings-four films	$54.00
O330	Panoramic film	$63.00
O451	Histopathologic Exam	$127.00
O460	Pulp vitality test	$66.00
O470	Diagnostic casts	$67.00
1110	Adult Prophy	$83.00
1120	Child Prophy	$83.00
1201	Child Prophy w/ Fluoride	$75.00
1203	Child Fluoride-No Prophy	$19.00
1204	Adult Fluoride	$39.00
1515	Fixed Bilateral Space Maintainer	$232.00
1520	Removable Unilateral Space Main.	$251.00
1525	Removable-Bilateral Space Maint.	$359.00
1351	SEALANT - PER TOOTH	$17.00
2140	AMALGAM - 1 SURFACE - PRIMARY OR PERMANENT	$41.00
2150	AMALGAM - 2 SURFACES - PRIMARY OR PERMANENT	$57.00
2160	AMALGAM - 3 SURFACES - PRIMARY OR PERMANENT	$69.00
2161	AMALGAM - 4+ SURFACES - PRIMARY OR PERMANENT	$83.00
2330	RESIN - 1 SURFACE ANTERIOR	$48.00
2331	RESIN - 2 SURFACES ANTERIOR	$63.00
2332	RESIN - 3 SURFACES ANTERIOR	$83.00
2335	RESIN - 4+ SURFACES OR INVOLVING INCISAL ANGLE - ANTERIOR	$87.00
2390	RESIN - BASED COMPOSITE CROWN - ANTERIOR	$117.00
2391	RESIN - BASED COMPOSITE - 1 SURFACE - POSTERIOR	$135.00
2392	RESIN - BASED COMPOSITE - 2 SURFACES-POSTERIOR	$160.00
2393	RESIN - BASED COMPOSITE - 3 SURFACES - POSTERIOR	$175.00
2394	RESIN - BASED COMPOSITE - 4+ SURFACES - POSTERIOR	$200.00
2410	GOLD FOIL - 1 SURFACE	$94.00
2420	GOLD FOIL - 2 SURFACES	$240.00
2430	GOLD FOIL - 3 SURFACES	$361.00
2510	INLAY METALLIC - 1 SURFACE	$391.00
2520	INLAY METALLIC - 2 SURFACES	$398.00
2530	INLAY METALLIC - 3+ SURFACES	$411.00
2542	ONLAY METALLIC - 2 SURFACES	$486.00
2543	ONLAY METALLIC - 3 SURFACES	$486.00
2544	ONLAY METALLIC - 4+ SURFACES	$486.00
2610	INLAY PORCELAIN/CERAMIC - 1 SURFACE	$452.00
2620	INLAY PORCELAIN/CERAMIC - 2 SURFACES	$452.00

2630	INLAY PORCELAIN/CERAMIC - 3+ SURFACES	$452.00
2642	ONLAY PORCELAIN/CERAMIC - 2 SURFACES	$452.00
2643	ONLAY PORCELAIN/CERAMIC - 3 SURFACES	$452.00
2644	ONLAY PORCELAIN/CERAMIC - 4+ SURFACES	$452.00
2650	INLAY - COMPOSITE/RESIN - 1 SURFACE - LAB	$452.00
2651	INLAY - COMPOSITE/RESIN - 2 SURFACES - LAB	$452.00
2652	INLAY - COMPOSITE/RESIN - 3+ OR MORE SURFACES - LAB	$452.00
2662	ONLAY COMPOSITE/RESIN - 2 SURFACES - LAB	$452.00
2663	ONLAY COMPOSITE/RESIN - 3 SURFACES - LAB	$452.00
2664	ONLAY COMPOSITE/RESIN - 4+ SURFACES - LAB	$452.00
2710	CROWN RESIN (LABORATORY)	$210.00
2720	CROWN RESIN WITH HIGH NOBLE METAL	$701.00
2721	CROWN RESIN WITH PREDOMINANTLY BASE METAL	$587.00
2722	CROWN RESIN WITH NOBLE METAL	$568.00
2740	CROWN PORCELAIN/CERAMIC SUBSTRATE	$634.00
2750	CROWN PORCELAIN FUSED TO HIGH NOBLE METAL	$618.00
2751	CROWN PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$594.00
2752	CROWN PORCELAIN FUSED TO NOBLE METAL	$596.00
2780	CROWN - 3/4 CAST HIGH NOBLE METAL	$611.00
2781	CROWN - 3/4 CAST PREDOMINATELY BASE METAL	$611.00
2782	CROWN - 3/4 CAST NOBLE METAL	$611.00
2783	CROWN - 3/4 PORCELAIN/CERAMIC	$611.00
2790	CROWN FULL CAST HIGH NOBLE METAL	$607.00
2791	CROWN FULL CAST PREDOMINANTLY BASE METAL	$561.00
2792	CROWN FULL CAST NOBLE METAL	$562.00
2799	PROVISIONAL CROWN	$77.00
2910	RECEMENT INLAY	$31.00
2920	RECEMENT CROWN	$31.00
2930	PREFAB STAINLESS STEEL CROWN - PRIMARY	$107.00
2931	PREFAB STAINLESS STEEL CROWN - PERMANENT	$107.00
2932	PREFABRICATED RESIN CROWN	$117.00
2933	PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW	$107.00
2940	SEDATIVE FILLING	$32.00
2950	CORE BUILDUP INCLUDING ANY PINS	$96.00
2951	PIN RETENTION - PER TOOTH - IN ADDITION TO RESTORATION	$26.00
2952	CAST POST & CORE IN ADDITION TO CROWN	$162.00
2954	PREFABRICATED POST & CORE IN ADDITION TO CROWN	$118.00
2970	TEMPORARY CROWN - FRACTURED TOOTH	$77.00
3110	PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)	$26.00
3120	PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)	$19.00
3220	THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION)	$62.00
3221	PULPAL DEBRIDEMENT - PRIMARY AND PERMANENT TEETH	$62.00
3230	PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR - PRIMARY TOOTH	$62.00
3240	PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR - PRIMARY TOOTH	$62.00
3310	ROOT CANAL THERAPY - ANTERIOR (EXCLUDING FINAL RESTORATION)	$444.00
3320	ROOT CANAL THERAPY - BICUSPID (EXCLUDING FINAL RESTORATION)	$538.00
3330	ROOT CANAL THERAPY - MOLAR (EXCLUDING FINAL RESTORATION)	$646.00
3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY (RCT) - ANTERIOR	$444.00

3347	RETREATMENT OF PREVIOUS RCT - BICUSPID	$538.00
3348	RETREATMENT OF PREVIOUS RCT - MOLAR	$680.00
3351	APEXIFICATION/RECALCIFICATION - INITIAL VISIT	$132.00
3352	APEXIFICATION/RECALCIFICATION - INTERIM MEDICATION REPLACEMENT	$132.00
3353	APEXIFICATION/RECALCIFICATION - FINAL VISIT	$132.00
3410	APICOECTOMY/PERIRADICULAR SURGERY - ANTERIOR	$213.00
3421	APICOECTOMY/PERIRADICULAR SURGERY - BICUSPID FIRST ROOT	$321.00
3425	APICOECTOMY/PERIRADICULAR SURGERY - MOLAR FIRST ROOT	$321.00
3430	RETROGRADE FILLING - PER ROOT	$305.00
3450	ROOT AMPUTATION - PER ROOT	$173.00
3910	SURGICAL PROCEDURE FOR ISOLATION OF TOOTH WITH RUBBER DAM	$204.00
3920	HEMISECTION (INCLUDING ANY ROOT REMOVAL)	$129.00
4210	GINGIVECTOMY OR GINGIVOPLASTY - PER QUADRANT	$189.00
4211	GINGIVECTOMY OR GINGIVOPLASTY - 1 - 3 TEETH	$53.00
4240	GINGIVAL FLAP PROCEDURE (INCLUDING ROOT PLANNING) - PER QUADRANT	$194.00
4241	GINGIVAL FLAP PROC. (INCL. ROOT PLANNING)1-3 TEETH-PER QUAD.	$97.00
4245	APICALLY POSITIONED FLAP	$194.00
4249	CLINICAL CROWN LENGTHENING - HARD TISSUE	$278.00
4260	OSSEOUS SURG (FLAP ENTRY AND CLOSURE) 4+ MORE TEETH PER QUAD	$464.00
4261	OSSEOUS SURG (FLAP ENTRY AND CLOSURE)1 -3 TEETH PER QUAD	$232.00
4263	BONE REPLACEMENT GRAFT - FIRST SITE IN QUADRANT	$196.00
4264	BONE REPLACEMENT GRAFT - EACH ADDITIONAL SITE IN QUADRANT	$298.00
4266	GUIDED TISSUE REGENERATION	$194.00
4267	GUIDED TISSUE REGENERATION	$194.00
4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	$283.00
4271	FREE SOFT TISSUE GRAFT PROCEDURE (INCL. DONOR SITE SURGERY)	$345.00
4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROCEDURE	$345.00
4274	DISTAL OR PROXIMAL WEDGE PROCEDURE	$128.00
4275	SOFT TISSUE ALLOGRAFT	$345.00
4276	COMBINED CONNECTIVE TISSUE AND DOUBLE PEDICAL GRAFT	$628.00
4341	PERIODONTAL SCALING AND ROOT PLANNING	$75.00
4342	PERIODONTAL SCALING AND ROOT PLANNING - 1 - 3 TEETH - PER QUADRANT	$37.00
4355	FULL MOUTH DEBRIDEMENT	$230.00
4910	PERIODONTAL MAINTENANCE PROCEDURES (FOLLOWING ACTIVE THERAPY)	$53.00
4920	UNSCHEDULED DRESSING CHANGE	$39.00
5110	COMPLETE DENTURE - MAXILLARY	$771.00
5120	COMPLETE DENTURE - MANDIBULAR	$752.00
5130	IMMEDIATE DENTURE - MAXILLARY	$803.00
5140	IMMEDIATE DENTURE - MANDIBULAR	$752.00
5211	MAXILLARY PARTIAL DENTURES – RESIN BASE	$825.00
5212	MANDIBULAR PARTIAL DENTURES – RESIN BASE	$825.00
5213	MAXILLARY PARTIAL DENTURES - CAST METAL FRAMEWORK	$800.00
5214	MANDIBULAR PARTIAL DENTURES - CAST METAL FRAMEWORK	$785.00
5281	REMOVABLE UNILATERAL PARTIAL DENTURE – 1 PIECE CAST METAL	$536.00
5410	ADJUST COMPLETE DENTURE - MAXILLARY	$41.00
5411	ADJUST COMPLETE DENTURE - MANDIBULAR	$29.00
5421	ADJUST PARTIAL DENTURE - MAXILLARY	$41.00
5422	ADJUST PARTIAL DENTURE -MANDIBULAR	$29.00

5510	REPAIR BROKEN COMPLETE DENTURE BASE	$64.00
5520	REPLACE MISSING OR BROKEN TEETH - COMPLETE DENTURE (EACH TOOTH)	$50.00
5610	REPAIR RESIN DENTURE BASE	$64.00
5620	REPAIR CAST FRAMEWORK	$69.00
5630	REPAIR OR REPLACE BROKEN CLASP	$44.00
5640	REPLACE BROKEN TEETH - PER TOOTH	$50.00
5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	$77.00
5660	ADD CLASP TO EXISTING PARTIAL DENTURE	$116.00
5670	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MAXILLARY)	$182.00
5671	REPLACE ALL TEETH AND ACRYLIC ON CAST METAL FRAMEWORK (MANDIBULAR)	$182.00
5710	REBASE COMPLETE MAXILLARY DENTURE.	$121.00
5711	REBASE COMPLETE MANDIBULAR DENTURE.	$121.00
5720	REBASE MAXILLARY PARTIAL DENTURE.	$106.00
5721	REBASE MANDIBULAR PARTIAL DENTURE.	$106.00
5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	$133.00
5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	$133.00
5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	$117.00
5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	$117.00
5750	RELINE COMPLETE MAXILLARY DENTURE (LAB)	$182.00
5751	RELINE COMPLETE MANDIBULAR DENTURE (LAB)	$182.00
5760	RELINE MAXILLARY PARTIAL DENTURE (LAB)	$172.00
5761	RELINE MANDIBULAR PARTIAL DENTURE (LAB)	$172.00
5810	INTERIM COMPLETE DENTURE (MAXILLARY)	$322.00
5811	INTERIM COMPLETE DENTURE (MANDIBULAR)	$399.00
5850	TISSUE CONDITIONING - MAXILLARY	$64.00
5851	TISSUE CONDITIONING - MANDIBULAR	$64.00
6058	ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN	$574.00
6059	ABUTMENT SUPP. PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)	$608.00
6060	ABUTMENT SUPP. PORC. FUSED TO METAL CROWN (PRED BASE METAL)	$574.00
6061	ABUTMENT SUPP. PORC. FUSED TO METAL CROWN (NOBLE METAL)	$585.00
6062	ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)	$587.00
6063	ABUTMENT SUPP. CAST METAL CROWN (PRED. BASE METAL)	$585.00
6064	ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)	$546.00
6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	$574.00
6066	IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN	$608.00
6067	IMPLANT SUPP.METAL CROWN (TITANIUM/ HIGH NOBLE METAL)	$587.00
6068	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/CERAMIC FPD	$574.00
6069	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD	$608.00
6070	ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD	$574.00
6071	ABUT. SUPP.RETAIN. FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)	$585.00
6072	ABUT. SUPP.RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)	$587.00
6073	ABUT. SUPP. RETAIN. FOR CAST METAL FPD (PRED. BASE METAL)	$585.00
6074	ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)	$546.00
6075	IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD	$574.00
6076	IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD	$608.00
6077	IMPLANT SUPPORTED RETAINER FOR CAST METAL FPD	$587.00
6210	PONTIC - CAST HIGH NOBLE METAL	$587.00
6211	PONTIC - CAST PREDOMINANTLY BASE METAL	$585.00

6212	PONTIC - CAST NOBLE METAL	$546.00
6240	PONTIC - PORCELAIN FUSED TO HIGH NOBLE METAL	$608.00
6241	PONTIC - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$574.00
6242	PONTIC - PORCELAIN FUSED TO NOBLE METAL	$585.00
6245	PONTIC - PORCELAIN/CERAMIC	$574.00
6250	PONTIC - RESIN WITH HIGH NOBLE METAL	$609.00
6251	PONTIC - RESIN WITH PREDOMINANTLY BASE METAL	$499.00
6252	PONTIC - RESIN WITH NOBLE METAL	$577.00
6253	PROVISIONAL PONTIC	$77.00
6600	INLAY - PORCELAIN/CERAMIC - 2 SURFACES	$253.00
6601	INLAY - PORCELAIN/CERAMIC - 3+ MORE SURFACES	$349.00
6602	INLAY - CAST HIGH NOBLE METAL - 2 SURFACES	$253.00
6603	INLAY - CAST HIGH NOBLE METAL - 3+ SURFACES	$349.00
6604	INLAY - CAST PREDOMINANTLY BASE METAL - 2 SURFACES	$253.00
6605	INLAY - CAST PREDOMINANTLY BASE METAL - 3+ SURFACES	$349.00
6606	INLAY - CAST NOBLE METAL - 2 SURFACES	$253.00
6607	INLAY - CAST NOBLE METAL - 3+ SURFACES	$349.00
6608	ONLAY - PORCELAIN/CERAMIC - 2 SURFACES	$354.00
6609	ONLAY - PORCELAIN/CERAMIC - 3+ SURFACES	$354.00
6610	ONLAY - CAST HIGH NOBLE METAL - 2 SURFACES	$354.00
6611	ONLAY - CAST HIGH NOBLE METAL - 3+ SURFACES	$354.00
6612	ONLAY - CAST PREDOMINANTLY BASE METAL - 2 SURFACES	$354.00
6613	ONLAY - CAST PREDOMINANTLY BASE METAL - 3+ SURFACES	$354.00
6614	ONLAY - CAST NOBLE METAL - 2 SURFACES	$354.00
6615	ONLAY - CAST NOBLE METAL - 3+ SURFACES	$354.00
6720	CROWN - RESIN WITH HIGH NOBLE METAL	$608.00
6721	CROWN - RESIN WITH PREDOMINANTLY BASE METAL	$605.00
6722	CROWN - RESIN WITH NOBLE METAL	$638.00
6740	CROWN - PORCELAIN/CERAMIC SUBSTRATE	$553.00
6750	CROWN - PORCELAIN FUSED TO HIGH NOBLE METAL	$613.00
6751	CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	$585.00
6752	CROWN - PORCELAIN FUSED TO NOBLE METAL	$594.00
6780	CROWN - 3/4 CAST HIGH NOBLE METAL	$561.00
6781	CROWN - 3/4 PREDOMINANTLY BASE METAL	$561.00
6782	CROWN - 3/4 CAST NOBLE METAL	$561.00
6783	CROWN - 3/4 PORCELAIN/CERAMIC	$561.00
6790	CROWN - FULL CAST HIGH NOBLE METAL	$605.00
6791	CROWN - FULL CAST PREDOMINANTLY BASE METAL	$552.00
6792	CROWN - FULL CAST NOBLE METAL	$555.00
6793	PROVISIONAL RETAINER CROWN	$77.00
6920	CONNECTOR BAR	$110.00
6930	RECEMENT FIXED PARTIAL DENTURE	$50.00
6940	STRESS BREAKER	$110.00
6950	PRECISION ATTACHMENT	$110.00
6970	CAST POST AND CORE IN ADDITION TO FIXED PARTIAL DENTURE RETAINER	$162.00
6971	CAST POST AS PART OF FIXED PARTIAL DENTURE RETAINER	$118.00
6972	PREFABRICATED POST AND CORE IN ADDITION TO FIXED PARTIAL DENTURE RETAINER	$118.00

6973	CORE BUILD UP FOR RETAINER - INCLUDING ANY PINS	$96.00
7111	CORONAL REMNANTS - DECIDUOUS TOOTH	$43.00
7140	EXTRACTION – ERUP.TOOTH OR EXP. ROOT(ELEV/ FORCEP REMOVAL)	$43.00
7210	SURGICAL REMOVAL OF ERUPTED TOOTH	$76.00
7220	REMOVAL OF IMPACTED TOOTH - SOFT TISSUE	$124.00
7230	REMOVAL OF IMPACTED TOOTH - PARTIALLY BONY	$171.00
7240	REMOVAL OF IMPACTED TOOTH - COMPLETELY BONY	$202.00
7241	REMOVAL OF IMPACTED TOOTH – SURGICAL COMPLICATIONS	$202.00
7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS	$75.00
7260	OROANTRAL FISTULA CLOSURE	$261.00
7261	PRIMARY CLOSURE OF A SINUS PERFORATION	$261.00
7270	TOOTH RE - IMPLANTATION	$189.00
7272	TOOTH TRANSPLANTATION	$189.00
7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	$178.00
7281	SURGICAL EXPOSURE OF IMPACTED/UNERUPTED TOOTH TO AID ERUPTION	$117.00
7285	BIOPSY OF ORAL TISSUE - HARD	$110.00
7286	BIOPSY OF ORAL TISSUE - SOFT	$118.00
7310	ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT	$89.00
7320	ALVEOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS - PER QUADRANT	$107.00
7340	VESTIBULOPLASTY - RIDE EXTENSION (SECONDARY EPITHELIALIZATION)	$136.00
7485	SURGICAL REDUCTION OF OSSEOUS TUBEROSITY	$107.00
7510	INCISION AND DRAINAGE OF ABSCESS - INTRAORAL SOFT TISSUE	$50.00
7880	OCCLUSAL ORTHOTIC DEVICE - BY REPORT (TMJ)	$366.00
7960	FRENULECTOMY (FRENECTOMY OR FENOTOMY) - SEPARATE PROCEDURE	$156.00
7970	EXCISION OF HYPERPLASTIC TISSUE - PER ARCH	$147.00
7971	EXCISION OF PERIOCORONAL GINGIVA	$37.00
7972	SURGICAL REDUCTION OF FIBROUS TUBEROSITY	$107.00
8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	$264.00
8021	LIMITED ORTHO - RECORDS	$160.00
8022	LIMITED ORTHO - INITIAL PLACEMENT	$264.00
8023	LIMITED ORTHO - MONTHLY (MONTHLY VISITS)	$53.00
8024	LIMITED ORTHO - RETENTION	$176.00
8031	LIMITED ORTHO - RECORDS	$160.00
8032	LIMITED ORTHO - INITIAL PLACEMENT	$264.00
8033	LIMITED ORTHO - MONTHLY (MONTHLY VISITS)	$53.00
8034	LIMITED ORTHO - RETENTION	$176.00
8041	LIMITED ORTHO - RECORDS	$160.00
8042	LIMITED ORTHO - INITIAL PLACEMENT	$264.00
8043	LIMITED ORTHO - MONTHLY (MONTHLY VISITS)	$53.00
8044	LIMITED ORTHO - RETENTION	$176.00
8051	INTERCEPTIVE ORTHO - RECORDS	$160.00
8052	INTERCEPTIVE ORTHO - INITIAL PLACEMENT	$264.00
8053	INTERCEPTIVE ORTHO - MONTHLY (MONTHLY VISITS)	$53.00
8054	INTERCEPTIVE ORTHO - RETENTION	$176.00
8061	INTERCEPTIVE ORTHO - RECORDS	$160.00
8062	INTERCEPTIVE ORTHO - INITIAL PLACEMENT	$264.00
8063	INTERCEPTIVE ORTHO - MONTHLY (MONTHLY VISITS)	$53.00
8064	INTERCEPTIVE ORTHO - RETENTION	$176.00

8071	COMPREHENSIVE ORTHO - RECORDS	$160.00
8072	COMPREHENSIVE ORTHO - INITIAL PLACEMENT	$811.00
8073	COMPREHENSIVE ORTHO - MONTHLY (MONTHLY VISITS)	$101.00
8074	COMPREHENSIVE ORTHO - RETENTION	$176.00
8081	COMPREHENSIVE ORTHO - RECORDS	$160.00
8082	COMPREHENSIVE ORTHO - INITIAL PLACEMENT	$811.00
8083	COMPREHENSIVE ORTHO - MONTHLY (MONTHLY VISITS)	$101.00
8084	COMPREHENSIVE ORTHO - RETENTION	$176.00
8091	COMPREHENSIVE ORTHO - RECORDS	$160.00
8092	COMPREHENSIVE ORTHO - INITIAL PLACEMENT	$811.00
8093	COMPREHENSIVE ORTHO - MONTHLY (MONTHLY VISITS)	$101.00
8094	COMPREHENSIVE ORTHO - RETENTION	$176.00
8210	REMOVABLE APP. THERAPY - CONTROL HARMFUL HABITS (REMOVABLE)	$264.00
8220	REMOVABLE APPLIANCE THERAPY - CONTROL HARMFUL HABITS (FIXED)	$264.00
8660	PRE - ORTHODONTIC TREATMENT VISIT	$44.00
8670	PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)	$101.00
8680	ORTHODONTIC RETENTION	$58.00
8692	REPLACEMENT OF LOST OR BROKEN RETAINER	$176.00
9110	PALLIATIVE (EMERGENCY) TX OF DENTAL PAIN - MINOR PROCEDURE	$29.00
9220	GENERAL ANESTHESIA - FIRST 30 MINUTES	$149.00
9310	CONSULTATION	$44.00
9410	HOUSE CALL	$75.00
9420	HOSPITAL CALL	$85.00
9910	APPLICATION OF DESENSITIZING MEDICAMENT	$21.00
9911	APP. OF DESENS.RESIN FOR CERVICAL AND/OR ROOT SURFACE-PER TOOTH	$21.00
9930	TX OF COMPLICATIONS (POST-SUR.) - UNUSUAL CIRCUMSTANCES. BR	$29.00
9952	OCCLUSAL ADJUSTMENT - COMPLETE	$176.00

These fees are based on Usual, Customary and Reasonable fees
Fees subject to change without prior notification.

The dentist is responsible for collecting from the patient the difference between what the insurance pays and the total reimbursement amount listed.