Examinations

Procedure	Description	Maximum Reimbursement
00150	Comprehensive oral evaluation	$22.00
00120	Periodic examination	$20.00
00140	Limited oral evaluation, problem focused	$20.00

Prophylaxes

Procedure	Description	Maximum Reimbursement
01120	Children under 12 years of age	$27.00
01110	Adult	$40.00

Fluoride Treatments

Procedure	Description	Maximum Reimbursement
01208	Topical Application of Fluoride	$16.00

Sealants

Procedure	Description	Maximum Reimbursement
01351	Sealant per tooth	$23.00

Covered to the end of month, age 14, on the first and second permanent molars and bicuspids once every three years.

Palliative Services

Procedure	Description	Maximum Reimbursement
09110	Emergency visit for relief of pain.	$23.00

In certain circumstances, when a palliative treatment and another procedure are performed during the same visit, the allowance for the palliative treatment will be included in the allowance of the other procedure.

Radiology

Procedure	Description	Maximum Reimbursement
00220	Intra-oral periapical (standard x-ray films): Initial periapical x-ray	$6.00
00230	Each additional film	$5.00
00210	Intraoral complete series (includes bitewings)	$51.00

00270	Initial Bitewing	$7.00
00272	Bitewings-two films	$14.00
00274	Bitewings-four films	$28.00
00330	Panoramic (panography)	$35.00

EmblemHealth will cover fourteen (14) standard periapical x-ray films or one (1) panoramic film once every three (3) years. EmblemHealth will also cover two (2) occlusal intra-oral x-ray films in a three (3) year period. Individual periapical x-rays performed on the same day as a full mouth series are not covered. Duplication of x-rays is not covered.

Space Maintainers and Mouth Guards

Procedure	Description	Maximum Reimbursement
01520	Space maintainer, removable, acrylic	$120.00
01510	Fixed, unilateral band type	$120.00
01515	Fixed, lingual or palatal arch band type	$150.00
01525	Space maintainer, removal, bilateral	$150.00
01550	Recementation space maintainer (dependents to age 19)	$40.00
09941	An athletic mouth guard	$70.00

Each dependent is covered for one mouth guard per lifetime. It must be prescribed by a dentist and used for athletic purposes.

Restorations (Fillings)

Procedure	Description	Maximum Reimbursement
02140	Amalgam — One surface, permanent	$40.00
02150	Amalgam —Two surfaces, permanent	$50.00
02160	Amalgam — Three surfaces, permanent	$58.00
02161	Amalgam — Four or more surfaces, permanent	$58.00
02330	Resin — one surface, anterior	$48.00
02331	Resin — two surfaces, anterior	$57.00
02332	Resin — three surfaces, anterior	$62.00
02335	Resin — four or more surfaces, anterior	$62.00
02391	Resin-based composite-1 surf posterior	$50.00
02392	Resin-based composite-2 surf posterior	$59.00
02393	Resin-based composite-3 surf posterior	$64.00

The Schedule of Allowances imposes a maximum benefit for fillings done on the same tooth by the same Dentist or Provider within a six (6) month period. EmblemHealth will not pay more than this maximum benefit for fillings for each Member in any six (6) month period.

Oral Surgery (Extractions)

Procedure	Description	Maximum Reimbursement
07240	*Removal of impacted tooth completely covered by bone	$155.00
07220	*Soft tissue impaction	$105.00
07230	*Partial bony impaction	$130.00

07210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap & removal of bone and/or section of tooth	$65.00
07111	Coronal remnants - decidious tooth	$35.00
07140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$42.00

Oral Surgery (Other than Extractions)

Procedure	Description	Maximum Reimbursement
07510	Incision and drainage of periodontal abscess	$35.00
07450	*Cyst removal	$75.00
07285	Biopsy and examination of oral tissue	$38.00

Periodontics

Procedure	Description	Maximum Reimbursement
04266	*Guided tissue regeneration	$125.00
04341	*Periodontal scaling and root planning (per quadrant); at least 5 teeth per quadrant	$50.00
04910	*Periodontal Prophy, max 2 treatments each per calendar year (starting 1/1/15) Periodontal prophy counted toward the 5 treatments per calendar year	$55.00
04211	Gingivectomy or gingivoplasty 1-3 contiguous teeth or tooth-bounded spaces per quadrant	$45.00
04210	Gingivectomy or gingivoplasty 4 or more contiguous teeth or tooth-bounded spaces per quadrant	$225.00
04260	*Osseous surgery (per quadrant); at least 5 teeth per quadrant	$400.00

Repeated periodontal surgeries or grafts will not be covered for a period of three (3) years from the date of the original surgery or graft.

Endodontics (Root Canal Therapy)

Procedure	Description	Maximum Reimbursement
03310	*Root canal therapy — anterior	$315.00
03320	*Root canal therapy — bicuspid	$390.00
03330	*Root canal therapy — molar	$470.00
03220	Therapeutic pulpotomy	$70.00

Pulpotomy is covered once per tooth, per lifetime. However, pulpotomy is not covered if root canal therapy was done on the tooth by the same Dentist or Provider within the prior three (3) month period.

If any combination of apicoectomy, root end amalgam and apical curettage is done on the same tooth by the same Dentist or Provider within a three (3) month period of root canal therapy, will not

apply the Scheduled amounts for these services. EmblemHealth will apply a combined allowance for these services.

Occlusal adjustments done on the same tooth and in conjunction with fillings, prosthetic services, root canal therapy or repairs, inlays and crowns are not covered.

The allowance for incision and drainage done within two (2) weeks of root canal therapy or periodontal surgery on the same tooth by the same Dentist or Provider will be deducted from the allowance for the root canal therapy or periodontal surgery.

Pulp capping is not covered.

Surgical replacement of rubber dam, recalcification of perforation, preparation of canal for post or dowels, and bleaching of discolored teeth are not covered.

Periapical Services

Procedure	Description	Maximum Reimbursement
03410	*Apicoectomy, single procedure	$210.00
03426	*Apicoectomy, each additional root	$105.00
03920	*Hemisection	$70.00

Miscellaneous Procedures

Procedure	Description	Maximum Reimbursement
09310	Consultation with dental specialist	$40.00

Repair and Replacement of Prosthetic Appliances

Procedure	Description	Maximum Reimbursement
05510	Repairing of broken denture, with or without broken teeth	$80.00
05520	Replacing missing or broken teeth, complete denture, each tooth	$50.00
05630	Replacing broken clasp	$100.00
06930	Recementing fixed bridge	$30.00
	Maximum repair allowance per family member per calendar year	$200.00

If the repair of a partial denture is done in conjunction with the insertion of a new denture in the same area of the mouth, EmblemHealth's allowance will be the Scheduled amount for the insertion of the new denture.

If a denture adjustment is performed in conjunction with palliative treatment, EmblemHealth's allowance will be the Scheduled amount for the palliative treatment.

If the repair of a broken denture is performed in the same arch as the insertion of a full denture, EmblemHealth's allowance will be the Scheduled amount for the insertion of the new denture.

The allowance for an upper or lower overdenture will be the Scheduled amount for full upper and lower dentures. There will be no benefits for any treatment of the abutment tooth or attachment tooth.

You are not covered for the replacement or the substitution of appliances unless five (5) years have passed since the appliance was inserted.

If a fixed bridge and partial denture are inserted in the same arch, only the partial denture is covered during the prosthetic replacement limitation period of five (5) years.

You are not covered for double or multiple abutments.

Crowns or pontics for attachment or clasp purposes are not covered unless the tooth is so broken down that it cannot be restored by fillings. A cantilever pontic used for attachment purposes is not covered.

Splints are not covered except when a missing tooth is being replaced. Only the portion replacing the missing tooth is covered.

Crowns used in splints for periodontal conditions are not covered.

Crown buildups done in connection with individual crowns and abutments are not covered.

Crowns and inlays used as abutments are not covered unless they are used as primary support for fixed appliances.

Precious metal material used in crowns is reimbursed at a base metal rate.

Duplication, rebase or chairside reline to a denture is limited to one (1) per denture in a five year period. This applies to both full and partial dentures.

Acrylic crowns are only covered on the six (6) anterior teeth. They must be laboratory processed and permanent. The allowance for acrylic crowns will be the Scheduled amount for single crowns, not the Scheduled amount for a bridge abutment or splint.

Rebase or repair of new dentures are not covered until six (6) months after insertion.

Adjustment of appliances is not covered within one (1) year of insertion.

EmblemHealth does not cover services or appliances used solely as an adjunct to periodontal care.

Precision attachment, metal coping, tissue conditioning and stress breakers are not covered.

Cosmetic surgery and/or treatment is not covered unless medically necessary.

There is not a separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for the completed, permanent service or appliance.

Administration of Anesthesia

Procedure	Description	Maximum Reimbursement
09220	*General anesthesia, first 30 minutes	$265.00
09221	*General anesthesia, additional 15 minutes	$80.00
09241	*Intravenous sedation; first 30 minutes	$265.00
09242	*Intravenous sedation; additional 15 minutes	$80.00

General anesthesia must be rendered in connection with a covered service. IV sedation is covered when administered according to the American Dental Association guidelines.

Prosthetics

(Including 12 months post-care)

Procedure	Description	Maximum Reimbursement
05110	*Complete dentures: Full permanent, upper jaw	$580.00
05120	*Complete dentures: Full permanent, lower jaw	$580.00
05211	*Upper partial denture— resin base (including any conventional clasps, rests and teeth)	$350.00
05212	*Lower partial denture—resin base (including any conventional clasps, rests and teeth)	$350.00
05213	*Upper partial denture—cast metal framework with resin denture bases	$620.00
05214	*Lower partial denture—cast metal framework with resin denture bases	$620.00
05281	*Removable unilateral partial denture with one piece cast metal	$245.00

Adjustment of appliance is not covered within one year of insertion. Precision attachment, metal coping, tissue conditioning, and stress breakers are not covered.

Other Prosthetic Services

Procedure	Description	Maximum Reimbursement
05650	*Adding teeth to partial denture to replace natural teeth	$75.00
05710	*Rebase full, upper jaw (lab processed)	$220.00
05711	*Rebase full, lower jaw (lab processed)	$220.00
05720	*Rebase partial, upper jaw (lab processed)	$160.00
05721	*Rebase partial, lower jaw (lab processed)	$160.00
05730	*Reline complete upper denture (chairside)	$100.00
05731	*Reline complete lower denture (chairside)	$100.00
05740	*Reline upper partial denture (chairside)	$85.00
05741	*Reline lower partial denture (chairside)	$85.00

The allowance for an upper or lower overdenture will be the Scheduled amount for full upper and lower dentures. There will be no benefits for any treatment of the abutment tooth or attachment tooth.

You are not covered for the replacement or substitution of appliances unless five (5) years have passed since the appliance was inserted.

If a fixed bridge and partial denture are inserted in the same arch, only the partial denture is covered during the prosthetic replacement limitation period of five (5) years.

Duplication, rebase or chairside reline to a denture is limited to one per-denture in a five year period. This applies to both full and partial dentures.

If a three surface inlay, crown or abutment is done on a tooth that has been filled within the last 6 months, EmblemHealth will deduct the schedule amount for the filling from its payment for the inlay, crown or abutment.

Prosthodontics, Fixed

Procedure	Description	Maximum Reimbursement
06211	*Pontic — cast predominately base metal	$275.00
06241	*Pontic — porcelain fused to predominately base metal	$300.00
06604	*Inlay – cast predominantly base metal, 2 surfaces	$200.00
06605	*Inlay – cast predominantly base metal, 3 or more surfaces	$325.00
06721	*Crown – resin with predominantly base metal	$350.00
06751	*Crown – porcelain fused to predominantly base metal	$400.00
06930	Recementing fixed bridge	$30.00

Major Restorative

Procedure	Description	Maximum Reimbursement
02751	*Crown — Porcelain fused to predominately base metal	$400.00
02791	*Crown — Full cast, predominately base metal	$325.00
02920	Recement crown	$30.00
02952	Cast post and core in addition to crown	$110.00
02954	Prefabricated post and core in addition to crown	$110.00
02960	*Labial veneer (laminate, chairside)	$140.00
02961	*Labial veneer (resin laminate, lab processed)	$340.00
02962	*Labial veneer (porcelain laminate, lab processed)	$340.00
D6010	Surgical placement of implant body: endosteal implant	$600.00

Crown buildups done in connection with individual crowns and abutments are not covered.

Each abutment and each pontic in a fixed bridge constitutes a unit in a bridge.

Crowns or pontics for attachments or clasp purposes are not covered unless the tooth is so broken down that it cannot be restored by fillings. A cantilever pontic used for attachment purposes is not covered.

There is not a separate allowance for a temporary service or appliance. The allowance for a temporary service or appliance is included in the allowance for a completed, permanent service or appliance. Precious metal material used in crown is reimbursed at a base metal rate. Crowns used as splints for periodontal conditions are not covered. Acrylic crowns are only covered on the six (6) anterior teeth. They must be laboratory processed and permanent. The allowance for acrylic crowns will be the Scheduled amount for single crowns, not the Scheduled amount for a bridge abutment or splint.

The charge for cementation of a crown/inlay is included in the allowance for the crown/inlay.

Posts are only covered if there is evidence of root canal therapy on the tooth. Pins are covered once every six (6) months. However, pins are not covered if they are inserted in conjunction with a prosthetic service. Core build-ups including pins are not covered.

The allowance for chairside laminates for anterior teeth will be the comparable maximum composite Scheduled amount.

Crowns and inlays used as abutments are not covered unless they are used as primary support for fixed appliances.

The allowance for an onlay will be the schedule amount for a three surface inlay.

Orthodontic Services — Predetermination Recommended

Procedure	Description	Maximum Reimbursement
08030	**Limited active orthodontia treatment	$117.10
08399	**Appliance fee and diagnostic workup	$550.00

Examination, study models, x-rays, diagnosis, construction and insertion of orthodontic appliances, including all previous prophylatic appliances, for tooth guidance, including multi-phasal orthodontia. Multi-Phasal Orthodontia services are included in your benefit under the administration of insertion of appliance up to a lifetime maximum of $550.

Procedure	Description	Maximum Reimbursement
08670	**Active orthodontic treatment up to 20 months each treatment	$117.10
08750	**Passive treatment up to a lifetime maximum of $108	$108.00

Your dentist should submit your regular initial appliance and workup fee as a separate charge with the code indicated.

EmblemHealth recommends pre-determinations for all dental services exceeding $300.00.