

**2025**

# **PEDIATRIC ESSENTIAL HEALTHCARE BENEFITS DENTAL PROCEDURE GUIDELINES AND SUBMISSION REQUIREMENTS**

October 2025



**MASSACHUSETTS**

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## About This Guide

Under the Patient Protection and Affordable Care Act (ACA), certain plans must cover “essential health benefits” (EHBs). Each state selects an existing health plan as a benchmark of what benefits must be included. Because Massachusetts selected the Child Health Insurance Plan (CHIP) as the benchmark plan, the pediatric dental benefits that were in that plan when it was selected in 2014 are considered Essential Health Benefits (EHB) in Massachusetts.

This guide is designed to provide you with procedure guidelines and submission requirements for the American Dental Association (ADA) Current Dental Terminology (CDT) procedure codes used to bill for pediatric EHBs.

We accept only coding that is consistent with the verbal descriptors of CDT. However, the presence of a code in CDT does not mean that a subscriber has coverage available. We determine member benefits on the basis of our administrative policies and the terms of the subscriber’s certificate. As always, we remind you to check benefits and eligibility before performing services.

Some of the categories of service have introductory sections to explain what information you need to provide to facilitate our claim processing. For a more complete description of procedures, please refer to the *American Dental Association, Current Dental Terminology – 2024*.

For each code, we have:

- Provided specific guidelines and recommendations with respect to time, age, or other contractual limitations or exclusions.
- Noted when procedures are not covered benefits.
- Indicated procedure codes that require radiographic (X-ray) imaging documentation and other supplementary documentation.

Please use this guide to determine the correct code to describe the service you provided to your patient. We hope that making our policies and guidelines clear and easily available will enable your office to receive the appropriate compensation for the services provided to our members, your patients.

# Administering your patients' pediatric EHBs

These benefits can be administered under the subscriber's medical benefit and considered separate from other stand alone Dental Blue plans. To help you bill for dental EHB's under the member's **medical benefit**, we want you to be aware of the following:

**Check eligibility and benefits.** These benefits are **only** available to our small group and self-pay plans, it is important for you to verify eligibility and benefits before delivering services. To check eligibility and benefits, you can:

- Use Change Healthcare Dental Connect (available on our website under etools)
- Call Dental Provider Service at **1-800-882-1178**
- Call our **InfoDial** system (available 24 hours a day, seven days a week) at **1-800-882-1178** and follow the prompts for benefits and eligibility

**Member benefits.** Blue Cross Blue Shield of Massachusetts members who have these benefits covered under their medical plan will have a Blue Cross Blue Shield of Massachusetts medical ID card. Members who have dental benefits covered by a stand-alone Dental Blue plan will have a Dental Blue ID card.

**Maximums.** The member's dental benefit maximums do not apply for services processed under the member's medical benefit. The provisions of the member's health plan govern coverage for these services. The member will have a separate maximum out of pocket (MOOP) benefit for pediatric dental benefits; after this maximum is met, coverage for pediatric dental benefits will not require a deductible, co-insurance, or a copayment.

**Participating Dentists.** You must be a participating dentist with Blue Cross Blue Shield of Massachusetts through the **Dental Blue** indemnity network to provide dental EHB's under the member's medical plan.

**Reimbursement.** We will reimburse Dental Blue participating dentists for pediatric dental EHB's using your submitted fee or the Dental Blue maximum allowable charge, whichever is less, minus the member's dental deductible, copayment, or co-insurance associated with the EHB plan.

**Medical cost-share.** When you provide services through the member's medical benefit, you must collect the member's cost-sharing (if applicable) to receive your whole reimbursement. The member's appropriate medical cost share may be a copayment (a fixed dollar amount), co-insurance (a percentage of the cost), or deductible (a first-dollar amount).

# Utilization management

This section includes information on our utilization management process, pre-treatment estimates, treatment review, and claim submission. Our dental utilization management team reviews certain types of procedures for quality of care, necessity, and appropriateness of treatment based on the documentation submitted. The team includes dentists, dental hygienists, and dental assistants.

We continue to conduct utilization review on submitted claims but do not routinely require submission of radiographs or periodontal charting from participating Dental Blue and Dental Blue PPO providers. Please refer to the *Submission Requirements* column for any specific requirements needed when submitting claims for treatment, and review the orthodontia section of this booklet for more information on how to submit prior authorization requests for orthodontic services.

## What is “necessary and appropriate treatment?”

Our members’ subscriber certificates specify that all dental care must be “necessary and appropriate to diagnose or treat your dental condition” and defines dental care as “inclusive of services, procedures, supplies and appliances.” The member’s subscriber certificates identify the following criteria used to determine whether dental care is necessary and appropriate for the member. The dental care must be:

- Consistent with the prevention and treatment of oral disease or with the diagnosis and treatment of teeth that are decayed or fractured, or where the supporting structure is weakened by disease (including periodontal, endodontic, and related diseases).
- Furnished in accordance with standards of good dental practice.
- Not solely for the member’s or dentist’s convenience.

## How do we determine necessity and appropriateness of treatment?

Based on a review of the submitted procedure documentation, our dental consultants determine available benefits for certain types of procedures, including, but not limited to, cast or milled restorations, periodontal services, oral surgery services, and fixed and removable prosthetics. A dental consultant reviews the treatment plan objectively and determines whether the services are within the scope of benefits, and whether these services appear to be necessary and appropriate for the member. Based on these findings, we may determine that a service is not *necessary and appropriate* for the member, even if a dentist has recommended, approved, prescribed, ordered, or furnished the service.

## Services that are non-covered due to contractual limitations

There are situations in which specific services are not covered regardless of whether the procedure is a covered benefit. These are considered contractual limitations and are outlined in the Subscriber Certificate under “Limitations and Exclusions.” Examples include a service performed for cosmetic purposes rather than for tooth decay or fracture or a service that is exploratory in nature.

## Information we need to review a procedure

We review procedures including, but not limited to, cast and milled restorations, periodontal services, oral surgery services, and fixed and removable prosthetics. To appropriately review a procedure, we may need pertinent documentation supporting your patient’s treatment. This *Guide* identifies the information you must submit for each procedure that requires review. **In cases where we request a detailed narrative, please supply details about the patient’s condition that will help us evaluate your claim and reimburse you appropriately.**

## Individual consideration process

In general, we do not pay for any procedure that is not fully described by a CDT code. However, in some circumstances we will approve the unlisted procedure code or a procedure that does not otherwise meet guidelines for submission under our individual consideration process. To find out if we will apply individual consideration to cover the procedure for your patient, please:

- Submit a pre-treatment estimate request to determine if we will apply individual consideration to cover the non-covered procedure.
- Use a detailed narrative and CDT code D0999, D1999, D2999, D3999, D4999, D5899, D5999, D6199, D6999, D7999, D8999, or D9999 depending on the type of individual consideration being requested for review.

We'll review the claim and notify you of the outcome through a provider payment advisory (PPA) and provider detail advisory (PDA).

## When documentation is requested

While we continue to conduct utilization review on submitted claims, we will no longer routinely require submission of radiographic imaging or periodontal charting from participating providers. Please refer to the *Submission Requirements* column for any specific requirements needed when submitting claims for treatment. Please remember that radiographs must be:

- Preoperative periapical radiographic imaging that are current and dated
- Labeled "right" or "left" side
- Mounted if they are a full series
- Of diagnostic quality

Please remember to include the member's name and ID and the dentist's name and address. **If documentation is not requested, any radiographic imaging submitted will not be returned.**

# Guidelines for specific services

## Endodontic services

Endodontic procedures include exam, pulp test, pulpotomy, pulpectomy, extirpation of pulp, pre-operative, operative and post-operative radiographs, filling of canals, bacteriologic cultures, and local anesthesia. Endodontic therapy performed specifically for coping or overdenture are not covered benefits.

Claims for multiple-stage procedures should only be billed on date of completion/insertion. Benefits are not available for incomplete care. Payment for endodontic services does not mean that benefits will be available for subsequent restorative services. Coverage for those services is still subject to exclusions listed under major restorative guidelines.

## Periodontal Services

### Procedure submission guidelines

When supporting documentation is requested for periodontal services, please refer to the submission guidelines as outlined in this section.

- A quadrant is defined as four or more teeth per quadrant.
- A partial quadrant is defined as one to three teeth per quadrant. For billing purposes, a *sextant* is not a recognized designation by the American Dental Association.
- Alveolar crestal bone loss and subgingival calculus must be evident radiographically for scaling and root planning to be considered for coverage.
- Laser Assisted New Attachment Procedures (LANAP) is not a covered benefit and should not be submitted using Osseous surgery codes.

When more than one periodontal service (codes D4000-D4999) is completed within the same site or quadrant on the same date of service, BCBSMA will pay for the more extensive treatment as payment for the total service.

Benefits for all periodontal services are limited to two quadrants per date of service. If you want to request an exception to this due to a medical condition that may require your patient to receive extended treatment, please include a detailed narrative including general or intravenous anesthesia record, medical condition and length of appointment time.

### Payment for periodontal surgical services

Payment for definitive periodontal service includes follow-up evaluation for both surgical and non-surgical procedures. We provide payment only for one surgical procedure per quadrant, per 36 months. No more than two quadrants of surgical or non-surgical services may be covered when done on the same date of service. To request an exception to the two quadrant limitation of coverage that may require your patient to receive extended periodontal treatment, please submit a detailed narrative including general or intravenous anesthesia record, medical condition, and length of appointment time with the claim form for consideration of coverage.

When localized procedures are performed in the same quadrant within 36 months, the payment will not exceed the full quadrant allowance. Periodontal services are benefits when performed for the treatment of periodontal disease around natural teeth. There are no benefits for these procedures when billed in conjunction with or in preparation for implants, ridge augmentation, extractions sites, and endodontic surgeries. When localized surgical or presurgical services are

performed in the same quadrants within coverage time guidelines, payment for the services will not exceed the full quadrant allowance.

## Prosthodontic services

Bill claims for multiple stage procedures on the date of completion/insertion of the final restoration. Treatments must be generally accepted dental practice and must be necessary and appropriate for the dental condition. The foundation of generally accepted dental practice continues to be:

- Establishing periodontal health prior to final phase restoration prosthetic dentistry.
- Avoiding incomplete or technically deficient endodontic treatment which is detrimental to the long-term prognosis of the tooth and subsequent oral health. All endodontic retreatments must be completed satisfactorily before prosthetic treatment consideration.
- Cantilever pontic in the natural dentition is only covered for the replacement of a missing lateral incisor with a natural canine, or canine and bicuspid.

Fixed prosthodontics will not be covered if certain conditions are present:

- Untreated bone loss
- An abutment tooth has poor-to-hopeless prognosis from either a restorative or periodontal perspective
- Periapical pathology or unresolved, incomplete, or failed endodontic therapy
- Service meant to treat TMJ, increase vertical dimension, or restore occlusion
- A bridge where one or more of the abutments is an implant.

## Orthodontic services

### Benefit administration

**Limited Orthodontic Treatment.** Use these codes for orthodontic treatment that involves a specific, defined, and limited scope. Treatment may occur in any stage of dental development or dentition. For example: Treatment of a single tooth in crossbite or a tooth that needs guidance during eruption.

**Comprehensive Orthodontic Treatment.** Use these codes when treatment involves correction of all of the patient's dentofacial issues including any skeletal, muscular, and dental alignment and occlusion issues. For example: 24-month treatment plan to correct crowding and alignment in both arches.

### How to submit claims for orthodontic treatment

**Limited Treatment.** Submit the ADA claim form with the appropriate CDT procedure code based on the patient's stage of dentition when the treatment started, total treatment charge and the date treatment began (date appliance placed). We will make payment after receipt of initial claim for treatment.

**Comprehensive Treatment.** For patients whose comprehensive treatment started after their orthodontic benefits became effective, submit the ADA claim form with the appropriate CDT procedure code based on the patient's stage of dentition when the treatment started, total treatment charge, total months of treatment and the date treatment began (date appliance placed).

We will make monthly payments for these comprehensive treatments. The initial monthly payment will be equal to 50% of the patient's orthodontic benefit maximum for covered services less any member cost share. We will pay the rest in monthly installments until the treatment plan is complete, or benefits are exhausted. You do not need to submit for these monthly claims; we will generate the payments automatically.

Refer to **Billing and Reimbursement** under **section 4** of the [Blue Book](#) for submission guidelines on any of the following cases:

- **“work in progress”** - comprehensive treatment began before the patient's orthodontic benefits became effective
- **“takeover-case”** - comprehensive treatment began in another office and you are completing the treatment plan for the patient
- **“continuation of treatment”** - comprehensive treatment that requires additional months of treatment than originally reported on the initial treatment plan submission.

**Multi-Phase Treatment.** There must be a minimum of a six month “rest period” between the completion of phase 1 and the start of phase 2, with all appliances from phase 1 treatment removed prior to the start of phase 2 treatment.

**Medically necessary orthodontic services.** Require an approved prior authorization (PA). To be eligible, a child must have a severe and handicapping malocclusion or misalignment of teeth. Only orthodontists are allowed to perform Essential Health Benefits (EHB) orthodontic services. Services rendered without obtaining a PA approval will not be covered. If prior authorization has not been requested or approved, the claim will deny. Authorizations will only be given to new cases and not takeover cases.

| To request PA for: Please:               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Medically necessary orthodontic services | <ol style="list-style-type: none"> <li>1. Submit the services requested on a dental claim form with the Pre-Treatment Estimate box checked.</li> <li>2. Include the appropriate documentation for review of Comprehensive Orthodontics (D8080/D8091) including Pre-Treatment Claim Form, HLD Index Form, Orthodontic prior authorization form, cephalometric and panoramic images, and photographic prints showing lateral, occlusal, and frontal views for comprehensive orthodontic cases.</li> <li>3. Include appropriate documentation for review of Limited Orthodontic (<b>D8010, D8020</b>) cases Pre-Treatment Claim Form, photographic prints, and the Orthodontic prior authorization form.</li> <li>4. Send the prior authorization request electronically, if possible. If your Pre-Treatment Estimate has been approved, you can consider this to be your approved prior authorization.</li> </ol> |
| Occlusal guards                          | <ol style="list-style-type: none"> <li>1. Submit the services requested on a dental claim form with the Pretreatment Estimate box checked.</li> <li>2. Submit a narrative stating the necessity and appropriateness of an occlusal guard for prior authorization of this service. Do not enter a date of service on the claim.</li> <li>3. Remember to: Enter an “X” in Box 1 of the claim form next to “Request for Predetermination/Prior authorization.” List the services to be included in the prior authorization.</li> </ol>                                                                                                                                                                                                                                                                                                                                                                             |

|  |                                                                                                                                                                                       |
|--|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|  | 4. Send the prior authorization request electronically, if possible. If your Pre-Treatment Estimate has been approved, you can consider this to be your approved prior authorization. |
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## Documents required for medically necessary prior authorization requests

Submit the following with the ADA Pre-Treatment Estimate form (**Note: Items 1, 4, and 5 are not required for Limited Orthodontic cases (D8010/ D8020):**

1. **Handicapping Labio-Lingual Deviations form.** Coverage for medically necessary orthodontics is determined by a minimum HLD Score of 22 or by an autoqualifier. Approval is based after consultant review of the appropriate documentation submitted.
2. **Pediatric Essential Health Benefits Prior Authorization form**
3. **Photographic Prints.** Photographic prints should be mounted, indicating the provider and patient names and the date.
  - Facial View: Be sure the patient's face is clearly discernible.
  - Lateral Views: Take views with sufficient soft tissue retraction to expose the buccal dentition, and as close to ninety degrees to the plane of the buccal dentition as possible (use of a mirror may be necessary.) The use of pediatric-size lip retractors facilitates sufficient soft tissue retraction. Photographs should allow evaluation of the antero-posterior relationship.
  - Occlusal Views: Take occlusal views with a mirror and retract so that the soft tissue of the lower lip does not cover the lower incisors. Try to include as many teeth as possible. Please measure the clinical widths of the maxillary and mandibular right central incisors, and enter the measurements on the HLD Recording Form.
4. **Cephalometric radiographic image**
5. **Panoramic radiographic image.** All teeth must be clearly visible.

We cannot prior authorize cases without complete information. We will return orthodontic records to the provider if submitted with a self-addressed, stamped return envelope.

## Billing for medically necessary orthodontic treatment

You must have an approved prior authorization before beginning treatment; failure to do so will result in a denial of payment(s). If the case is:

- **Approved:** Submit the ADA claim form in accordance with the approved prior authorization, total treatment charge, total months of treatment and the date treatment began (date appliance placed). Payment (total case allowance – member's cost share) will be made monthly over the course of treatment. The member must be eligible on the date of service. The overall case allowance includes the allowance for the pre-orthodontic records, retention (D8680) and follow-up visits; these are not separately reimbursed. You may not bill members for broken, repaired, or replacement brackets or wires.
- **Denied:** Submit the ADA claim form for CDT procedure code D8660 that includes all components of the orthodontic work-up. We will make payment after receipt of initial claim for treatment.

| CDT Code | ADA Category | Description of Service                                                                       | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                                                                         | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                     | Submission Requirements |
|----------|--------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| D0120    | Diagnostic   | Periodic oral evaluation – established patient                                               | Two per calendar year of D0145 or D0120. Considered inclusive when performed on the same day as palliative treatment by the same dentist/dental office.<br><br>Note: One evaluation code may be billed per dentist per date of service. Evaluations including diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist. | Two per calendar year. Considered inclusive when performed on the same day as palliative treatment by the same dentist/dental office.<br><br>Note: One evaluation code may be billed per dentist per date of service. Evaluations including diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist. | None                    |
| D0140    | Diagnostic   | Limited oral evaluation – problem-focused                                                    | Two per calendar year. Considered inclusive when performed on the same day as palliative treatment by the same dentist/dental office.<br><br>Note: One evaluation code may be billed per dentist per date of service. Evaluations including diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist.                   | Two per calendar year. Considered inclusive when performed on the same day as palliative treatment by the same dentist/dental office.<br><br>Note: One evaluation code may be billed per dentist per date of service. Evaluations including diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist. | None                    |
| D0145    | Diagnostic   | Oral evaluation for a patient under three years of age and counseling with primary caregiver | Two per calendar year of D0145 or D0120.<br><br>Note: One evaluation code may be billed per dentist per date of service. Evaluations including diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist.                                                                                                                | Not a covered benefit.<br><br>Note: One evaluation code may be billed per dentist per date of service. Evaluations including diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist.                                                                                                                | None                    |
| D0150    | Diagnostic   | Comprehensive oral evaluation - new or established patient                                   | One per member per lifetime, per dentist or location.<br><br>Note: One evaluation code may be billed per dentist per date of service. Evaluations including                                                                                                                                                                                                                          | Once per 60 months per dentist or location. Considered inclusive when performed on the same day as palliative treatment by the same dentist/dental office.                                                                                                                                                                                                         | None                    |

| CDT Code | ADA Category | Description of Service                                                                   | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                                                       | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                          | Submission Requirements |
|----------|--------------|------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
|          |              |                                                                                          | diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist.                                                                                                                                                                                                                                             | Note: One evaluation code may be billed per dentist per date of service. Evaluations including diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist.                                                                                                                                                                                                                                   |                         |
| D0160    | Diagnostic   | Detailed, extensive oral evaluation – problem-focused, by report                         | Two per twelve months, by report. Considered inclusive when performed same day as palliative treatment by same dentist/dental office.<br><br>Note: One evaluation code may be billed per dentist per date of service. Evaluations including diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist. | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                                                                                                                  | Detailed narrative      |
| D0170    | Diagnostic   | Re-evaluation – limited, problem focused (established patient; not post-operative visit) | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                             | Two per twelve months. Not to be used as a periodontal reevaluation. Considered inclusive when performed on the same day as any other definitive service including palliative treatment by the same dentist/dental office.<br><br>Note: One evaluation code may be billed per dentist per date of service. Evaluations including diagnosis and treatment planning is the responsibility of the dentist. All evaluations must be completed by a dentist. | None                    |
| D0171    | Diagnostic   | Re-evaluation – post operative office visit                                              | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                             | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                                                                                                                  | None                    |
| D0180    | Diagnostic   | Comprehensive periodontal evaluation – new or established patient                        | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                             | Once per 60 months per dentist or location. Considered inclusive when                                                                                                                                                                                                                                                                                                                                                                                   | None                    |

| CDT Code | ADA Category | Description of Service                                                                                        | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                     | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                        | Submission Requirements |
|----------|--------------|---------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
|          |              |                                                                                                               |                                                                                                                                                                                                                                  | performed on the same day as palliative treatment by the same dentist/dental office.                                                                                                                                  |                         |
| D0190    | Diagnostic   | Screening of a patient                                                                                        | Not a covered benefit.                                                                                                                                                                                                           | Not a covered benefit.                                                                                                                                                                                                | None                    |
| D0191    | Diagnostic   | Assessment of a patient                                                                                       | Not a covered benefit.                                                                                                                                                                                                           | Not a covered benefit.                                                                                                                                                                                                | None                    |
| D0210    | Diagnostic   | Intraoral – comprehensive series of radiographic images                                                       | One full mouth series (D0210) or panorex (D0330) per three calendar years and consists of a minimum of 7 or more radiographs, including bitewings.                                                                               | One full mouth series (D0210) or panorex (D0330) per 60 months and consists of a minimum of 7 or more radiographs, including bitewings.                                                                               | None                    |
| D0220    | Diagnostic   | Intraoral – periapical first radiographic image                                                               | One per day per member per (provider or location). Twelve of (D0220, D0230) per 12 months per member. If reported with Endodontics therapy, radiographs are included in the fee for the procedure.                               | A maximum of 6 radiographs per date of service. Any combination of radiographs that exceed 6 will be processed as D0210. If reported with Endodontics therapy, radiographs are included in the fee for the procedure. | None                    |
| D0230    | Diagnostic   | Intraoral - periapical each additional radiographic image                                                     | Three per day per member per (provider or location). Twelve of (D0220, D0230) per 12 months per member. If reported with Endodontics therapy, radiographs are included in the fee for the procedure.                             | A maximum of 6 radiographs per date of service. Any combination of radiographs that exceed 6 will be processed as D0210. If reported with Endodontics therapy, radiographs are included in the fee for the procedure. | None                    |
| D0240    | Diagnostic   | Intraoral - occlusal radiographic image                                                                       | Not a covered benefit.                                                                                                                                                                                                           | One film per arch per 6 months.                                                                                                                                                                                       | None                    |
| D0250    | Diagnostic   | Extra-oral – first 2D projection radiographic image created using a stationary radiation source, and detector | Not a covered benefit.                                                                                                                                                                                                           | Not a covered benefit.                                                                                                                                                                                                | None                    |
| D0251    | Diagnostic   | Extra-oral posterior dental radiographic image                                                                | Not a covered benefit.                                                                                                                                                                                                           | Not a covered benefit.                                                                                                                                                                                                | None                    |
| D0270    | Diagnostic   | Bitewing - single radiographic image                                                                          | Two per calendar year per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. If reported within 6 months of D0330, we will make an allowance for the difference between the payment of the | One per 6 months per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. If reported within 6 months of D0330, we will make an allowance for the difference                      | None                    |

| CDT Code | ADA Category | Description of Service                                                                                                | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                          | Submission Requirements |
|----------|--------------|-----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
|          |              |                                                                                                                       | panoramic and a full series of radiographs.                                                                                                                                                                                                                                  | between the payment of the panoramic and a full series of radiographs.                                                                                                                                                                                                  |                         |
| D0272    | Diagnostic   | Bitewings - two radiographic images                                                                                   | Two per calendar year per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. If reported within 6 months of D0330, we will make an allowance for the difference between the payment of the panoramic and a full series of radiographs. | One per 6 months per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. If reported within 6 months of D0330, we will make an allowance for the difference between the payment of the panoramic and a full series of radiographs. | None                    |
| D0273    | Diagnostic   | Bitewings - three radiographic images                                                                                 | Two per calendar year per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. If reported within 6 months of D0330, we will make an allowance for the difference between the payment of the panoramic and a full series of radiographs. | One per 6 months per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. If reported within 6 months of D0330, we will make an allowance for the difference between the payment of the panoramic and a full series of radiographs. | None                    |
| D0274    | Diagnostic   | Bitewings - four radiographic images                                                                                  | Two per calendar year per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. If reported within 6 months of D0330, we will make an allowance for the difference between the payment of the panoramic and a full series of radiographs. | One per 6 months per member. Bitewing radiographs reported within 6 months of D0210 are considered inclusive. If reported within 6 months of D0330, we will make an allowance for the difference between the payment of the panoramic and a full series of radiographs. | None                    |
| D0277    | Diagnostic   | Vertical bitewings – 7 to 8 radiographic images. This does not constitute a full mouth intraoral radiographic series. | Not a covered benefit.                                                                                                                                                                                                                                                       | One set per 12 months.                                                                                                                                                                                                                                                  | None                    |
| D0310    | Diagnostic   | Sialography                                                                                                           | Not a covered benefit.                                                                                                                                                                                                                                                       | Not a covered benefit.                                                                                                                                                                                                                                                  | None                    |
| D0320    | Diagnostic   | Temporomandibular joint arthrogram, including injection                                                               | Not a covered benefit.                                                                                                                                                                                                                                                       | Not a covered benefit.                                                                                                                                                                                                                                                  | None                    |
| D0321    | Diagnostic   | Other temporomandibular joint radiographic images, by report                                                          | Not a covered benefit.                                                                                                                                                                                                                                                       | Not a covered benefit.                                                                                                                                                                                                                                                  | None                    |

| CDT Code | ADA Category | Description of Service                                                                                                | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                               | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                  | Submission Requirements |
|----------|--------------|-----------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| D0322    | Diagnostic   | Tomographic survey                                                                                                    | Not a covered benefit.                                                                                                                                                                                                                                     | Not a covered benefit.                                                                                                                                                                                                                          | None                    |
| D0330    | Diagnostic   | Panoramic radiographic image                                                                                          | One full mouth series (D0210) or panorex (D0330) per three calendar years. Submit bitewing radiographs done in conjunction with a panoramic on a separate line; we will pay for the difference between the panorex and a full mouth series of radiographs. | One full mouth series (D0210) or panorex (D0330) per 60 months. Submit bitewing radiographs done in conjunction with a panoramic on a separate line; we will pay for the difference between the panorex and a full mouth series of radiographs. | None                    |
| D0340    | Diagnostic   | 2D cephalometric radiographic image – acquisition, measurement, and analysis                                          | Covered benefit for orthodontic services.                                                                                                                                                                                                                  | Not a covered benefit.                                                                                                                                                                                                                          | None                    |
| D0350    | Diagnostic   | 2D oral/facial photographic image obtained intra-orally or extra-orally                                               | Not a covered benefit.                                                                                                                                                                                                                                     | Covered only when the Plan requests that photos be submitted for utilization review. Otherwise, not covered.                                                                                                                                    | None                    |
| D0364    | Diagnostic   | Cone beam CT capture and interpretation with limited field of view – less than one whole jaw                          | Not a covered benefit.                                                                                                                                                                                                                                     | Not a covered benefit.                                                                                                                                                                                                                          | None                    |
| D0365    | Diagnostic   | Cone beam CT capture and interpretation with limited field of one full dental arch – mandible                         | Not a covered benefit.                                                                                                                                                                                                                                     | Not a covered benefit.                                                                                                                                                                                                                          | None                    |
| D0366    | Diagnostic   | Cone beam CT capture and interpretation with field of view of one full dental arch – maxilla, with or without cranium | Not a covered benefit.                                                                                                                                                                                                                                     | Not a covered benefit.                                                                                                                                                                                                                          | None                    |
| D0367    | Diagnostic   | Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium                      | Not a covered benefit.                                                                                                                                                                                                                                     | Not a covered benefit.                                                                                                                                                                                                                          | None                    |
| D0368    | Diagnostic   | Cone beam CT capture and interpretation for TMJ series including two or more exposures                                | Not a covered benefit.                                                                                                                                                                                                                                     | Not a covered benefit.                                                                                                                                                                                                                          | None                    |
| D0369    | Diagnostic   | Maxillofacial MRI capture and interpretation                                                                          | Not a covered benefit.                                                                                                                                                                                                                                     | Not a covered benefit.                                                                                                                                                                                                                          | None                    |
| D0370    | Diagnostic   | Maxillofacial ultrasound capture and interpretation                                                                   | Not a covered benefit.                                                                                                                                                                                                                                     | Not a covered benefit.                                                                                                                                                                                                                          | None                    |
| D0371    | Diagnostic   | Sialoendoscopy capture and interpretation                                                                             | Not a covered benefit.                                                                                                                                                                                                                                     | Not a covered benefit.                                                                                                                                                                                                                          | None                    |
| D0372    | Diagnostic   | Intraoral tomosynthesis – comprehensive series of radiographic images                                                 | Not a covered benefit.                                                                                                                                                                                                                                     | Not a covered benefit.                                                                                                                                                                                                                          | None                    |
| D0373    | Diagnostic   | Intraoral tomosynthesis – bitewing radiographic image                                                                 | Not a covered benefit.                                                                                                                                                                                                                                     | Not a covered benefit.                                                                                                                                                                                                                          | None                    |

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| D0374    | Diagnostic   | Intraoral tomosynthesis – periapical radiographic image                                                                                | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0380    | Diagnostic   | Cone beam CT image capture with limited field of view – less than one whole jaw                                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0381    | Diagnostic   | Cone beam CT image capture with field of view of one full dental arch – mandible                                                       | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0382    | Diagnostic   | Cone beam CT image capture with field of view of one full dental arch – maxilla, with or without cranium                               | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0383    | Diagnostic   | Cone beam CT image capture with field of view of both jaws, with or without cranium                                                    | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0384    | Diagnostic   | Cone beam CT image capture for TMJ series including two or more exposures                                                              | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0385    | Diagnostic   | Maxillofacial MRI image capture                                                                                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0386    | Diagnostic   | Maxillofacial ultrasound image capture                                                                                                 | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0387    | Diagnostic   | Intraoral tomosynthesis – comprehensive series of radiographic images – image capture only                                             | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0388    | Diagnostic   | Intraoral tomosynthesis – bitewing radiographic image – image capture only                                                             | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0389    | Diagnostic   | Intraoral tomosynthesis – periapical radiographic image – image capture only                                                           | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0391    | Diagnostic   | Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0393    | Diagnostic   | Virtual treatment simulation using 3D image volume or surface scan                                                                     | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0394    | Diagnostic   | Digital subtraction of two or more images or image volumes of the same modality to demonstrate changes that occurred over time         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0395    | Diagnostic   | Fusion of two or more 3D image volumes of one or more modalities                                                                       | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0396    | Diagnostic   | 3D printing of a 3D dental surface scan                                                                                                | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0411    | Diagnostic   | HbA1c in-office point-of-service testing                                                                                               | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0412    | Diagnostic   | Blood glucose level test – in-office using a glucose meter                                                                             | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D0414    | Diagnostic   | Laboratory processing of microbial specimen to include culture and sensitivity studies, preparation and transmission of written report | Not a covered benefit.                       | Not a covered benefit.                         | None                    |

| CDT Code | ADA Category | Description of Service                                                                                                                                                    | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                | Adult EHB Procedure Guidelines Ages 19 & older                                                                                              | Submission Requirements |
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| D0415    | Diagnostic   | Collection of microorganisms for culture and sensitivity                                                                                                                  | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0416    | Diagnostic   | Viral culture. A diagnostic test to identify viral organisms, most often herpes virus.                                                                                    | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0417    | Diagnostic   | Collection and preparation of saliva sample for laboratory diagnostic testing                                                                                             | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0418    | Diagnostic   | Analysis of saliva sample. Chemical or biological analysis of saliva sample for diagnostic purposes.                                                                      | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0419    | Diagnostic   | Assessment of salivary flow by measurement                                                                                                                                | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0422    | Diagnostic   | Collection and preparation of genetic sample material for laboratory analysis and report                                                                                  | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0423    | Diagnostic   | Genetic test for susceptibility to diseases – specimen analysis                                                                                                           | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0425    | Diagnostic   | Caries susceptibility tests. Not to be used for carious dentin staining.                                                                                                  | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0431    | Diagnostic   | Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0460    | Diagnostic   | Pulp vitality tests                                                                                                                                                       | Considered inclusive of other evaluation or endodontic services performed on the same day. Not a covered benefit in any other circumstance. | Considered inclusive of other evaluation or endodontic services performed on the same day. Not a covered benefit in any other circumstance. | None                    |
| D0470    | Diagnostic   | Diagnostic casts                                                                                                                                                          | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0472    | Diagnostic   | Accession of tissue, gross examination, preparation and transmission of written report                                                                                    | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0473    | Diagnostic   | Accession of tissue, gross and microscopic examination, preparation and transmission of written report                                                                    | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0474    | Diagnostic   | Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report  | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0475    | Diagnostic   | Decalcification procedure                                                                                                                                                 | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |
| D0476    | Diagnostic   | Special stains for microorganisms                                                                                                                                         | Not a covered benefit.                                                                                                                      | Not a covered benefit.                                                                                                                      | None                    |

| CDT Code | ADA Category | Description of Service                                                                                                                 | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                           | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                         | Submission Requirements |
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| D0477    | Diagnostic   | Special stains, not for microorganisms                                                                                                 | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0478    | Diagnostic   | Immunohistochemical stains                                                                                                             | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0479    | Diagnostic   | Tissue in-site hybridization, including interpretation                                                                                 | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0480    | Diagnostic   | Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report                     | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0481    | Diagnostic   | Electron microscopy                                                                                                                    | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0482    | Diagnostic   | Direct immunofluorescence                                                                                                              | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0483    | Diagnostic   | Indirect immunofluorescence                                                                                                            | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0484    | Diagnostic   | Consultation on slides prepared elsewhere                                                                                              | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0485    | Diagnostic   | Consultation, including preparation of slides from biopsy material supplied by referring source                                        | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0486    | Diagnostic   | Laboratory accession of transepithelial cytologic sample, microscopic examination, preparation, and transmission of written report     | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0502    | Diagnostic   | Other oral pathology procedures, by report                                                                                             | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0600    | Diagnostic   | Non-ionizing diagnostic procedure capable of quantifying, monitoring and recording changes in structure of enamel, dentin and cementum | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0601    | Diagnostic   | Caries risk assessment and documentation, with a finding of low risk                                                                   | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0602    | Diagnostic   | Caries risk assessment and documentation, with a finding of moderate risk                                                              | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0603    | Diagnostic   | Caries risk assessment and documentation, with a finding of high risk                                                                  | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                 | None                    |
| D0604    | Diagnostic   | Antigen testing for a public health-related pathogen including coronavirus                                                             | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurance for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurance for possible coverage. | None                    |
| D0605    | Diagnostic   | Antibody testing for a public health-related pathogen including coronavirus                                                            | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's                                          | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's                                          | None                    |

| CDT Code | ADA Category | Description of Service                                                                       | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                           | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                             | Submission Requirements |
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|          |              |                                                                                              | medical insurance for possible coverage.                                                                                                               | medical insurance for possible coverage.                                                                                                                                                                                   |                         |
| D0606    | Diagnostic   | Molecular testing for a public health-related pathogen, including coronavirus                | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurance for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurance for possible coverage.                                                                     | None                    |
| D0701    | Diagnostic   | Panoramic radiographic image – image capture only                                            | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0702    | Diagnostic   | 2D cephalometric radiographic image – image capture only                                     | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0703    | Diagnostic   | 2D oral/facial photographic image obtained intra-orally or extra-orally – image capture only | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0705    | Diagnostic   | Extra-oral posterior dental radiographic image – image capture only                          | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0706    | Diagnostic   | Intraoral – occlusal radiographic image – image capture only                                 | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0707    | Diagnostic   | Intraoral – periapical radiographic image – image capture only                               | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0708    | Diagnostic   | Intraoral – bitewing radiographic image – image capture only                                 | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0709    | Diagnostic   | Intraoral – comprehensive series of radiographic images – image capture only                 | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0801    | Diagnostic   | 3D intraoral surface scan – direct                                                           | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0802    | Diagnostic   | 3D dental surface scan – indirect                                                            | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0803    | Diagnostic   | 3D facial surface scan – direct                                                              | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0804    | Diagnostic   | 3D facial surface scan – indirect                                                            | Not a covered benefit.                                                                                                                                 | Not a covered benefit.                                                                                                                                                                                                     | None                    |
| D0999    | Diagnostic   | Unspecified diagnostic procedure, by report                                                  | Individual consideration.                                                                                                                              | Individual consideration.                                                                                                                                                                                                  | Detailed narrative      |
| D1110    | Preventive   | Prophylaxis – adult                                                                          | Two per calendar year. Use D1110 for ages 14+                                                                                                          | Two per calendar year. There must be at least three months between a periodontal maintenance cleaning and any other cleanings. D1110 and D4346 are considered inclusive of D4341 and D4342 when performed on the same day. | None                    |
| D1120    | Preventive   | Prophylaxis – child                                                                          | Two per calendar year. Use D1120 for ages 0 – 13                                                                                                       | Not a covered benefit.                                                                                                                                                                                                     | None                    |

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| D1206    | Preventive   | Topical application of fluoride varnish                                                                                                | Once per 90 day(s) of either code D1206 or D1208.                                                                                                                                                                            | Not a covered benefit.                         | None                                               |
| D1208    | Preventive   | Topical application of fluoride-excluding varnish                                                                                      | Once per 90 day(s) of either code D1206 or D1208.                                                                                                                                                                            | Not a covered benefit.                         | None                                               |
| D1301    | Preventive   | Immunization counseling                                                                                                                | Not a covered benefit.                                                                                                                                                                                                       | Not a covered benefit.                         | None                                               |
| D1310    | Preventive   | Nutritional counseling for control of dental disease                                                                                   | Not a covered benefit.                                                                                                                                                                                                       | Not a covered benefit.                         | None                                               |
| D1320    | Preventive   | Tobacco counseling for control and prevention of oral disease                                                                          | Not a covered benefit.                                                                                                                                                                                                       | Not a covered benefit.                         | None                                               |
| D1321    | Preventive   | Counseling for control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use | Not a covered benefit.                                                                                                                                                                                                       | Not a covered benefit.                         | None                                               |
| D1330    | Preventive   | Oral hygiene instructions                                                                                                              | Not a covered benefit.                                                                                                                                                                                                       | Not a covered benefit.                         | None                                               |
| D1351    |              | Sealant – per tooth                                                                                                                    | Under age 9: Covered for primary and permanent molars. Reapplication only if process fails within three years. Age 9 to under age 19: Covered for permanent non-carious molars for members once every three years per tooth. | Not a covered benefit.                         | Tooth identification<br><br>Surface identification |
| D1352    | Preventive   | Preventive resin restoration in a moderate to high caries risk patient-permanent tooth                                                 | Not a covered benefit.                                                                                                                                                                                                       | Not a covered benefit.                         | None                                               |
| D1353    | Preventive   | Sealant repair – per tooth                                                                                                             | Not a covered benefit.                                                                                                                                                                                                       | Not a covered benefit.                         | Tooth identification<br><br>Surface identification |
| D1354    | Preventive   | Application of caries- arresting medicament – per tooth                                                                                | Not a covered benefit.                                                                                                                                                                                                       | Not a covered benefit.                         | None                                               |
| D1355    | Preventive   | Caries preventive medicament application – per tooth, for primary prevention or remineralization.                                      | Not a covered benefit.                                                                                                                                                                                                       | Not a covered benefit.                         | None                                               |
| D1510    | Preventive   | Space maintainer – fixed – unilateral – per quadrant                                                                                   | Covered benefit.                                                                                                                                                                                                             | Not a covered benefit.                         | Quadrant identification                            |
| D1516    | Preventive   | Space maintainer – fixed – bilateral, maxillary                                                                                        | Covered benefit.                                                                                                                                                                                                             | Not a covered benefit.                         | Arch identification                                |
| D1517    | Preventive   | Space maintainer-fixed-bilateral, mandibular                                                                                           | Covered benefit.                                                                                                                                                                                                             | Not a covered benefit.                         | Arch identification                                |
| D1520    | Preventive   | Space maintainer – removable –unilateral – per quadrant                                                                                | Covered benefit.                                                                                                                                                                                                             | Not a covered benefit.                         | Quadrant identification                            |

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| D1526    | Preventive   | Space maintainer – removable – bilateral, maxillary             | Covered benefit.                                                                                                                                     | Not a covered benefit.                                                                                                                               | Arch identification     |
| D1527    | Preventive   | Space maintainer – removable – bilateral, mandibular            | Covered benefit.                                                                                                                                     | Not a covered benefit.                                                                                                                               | Arch identification     |
| D1551    | Preventive   | Re-cement or re-bond bilateral space maintainer – maxillary     | Covered benefit.                                                                                                                                     | Not a covered benefit.                                                                                                                               | Arch identification     |
| D1552    | Preventive   | Re-cement or re-bond bilateral space maintainer – mandibular    | Covered benefit.                                                                                                                                     | Not a covered benefit.                                                                                                                               | Arch identification     |
| D1553    | Preventive   | Re-cement or re-bond unilateral space maintainer – per quadrant | Covered benefit.                                                                                                                                     | Not a covered benefit.                                                                                                                               | Arch identification     |
| D1556    | Preventive   | Removal of fixed unilateral space maintainer – per quadrant     | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D1557    | Preventive   | Removal of fixed bilateral space maintainer – maxillary         | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D1558    | Preventive   | Removal of fixed bilateral space maintainer – mandibular        | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D1575    | Preventive   | Distal shoe space maintainer- fixed unilateral – per quadrant   | Once per arch or quadrant per lifetime.                                                                                                              | Not a covered benefit.                                                                                                                               | Quadrant identification |
| D1701    | Preventive   | Pfizer-BioNTech COVID-19 vaccine administration – first dose    | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage. | None                    |
| D1702    | Preventive   | Pfizer-BioNTech COVID-19 vaccine administration – second dose   | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage. | None                    |
| D1703    | Preventive   | Moderna COVID-19 vaccine administration – first dose            | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage. | None                    |
| D1704    | Preventive   | Moderna COVID-19 vaccine administration – second dose           | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage. | None                    |
| D1705    | Preventive   | AstraZeneca COVID-19 vaccine administration – first dose        | Not a covered benefit under Blue Cross Blue Shield of                                                                                                | Not a covered benefit under Blue Cross Blue Shield of                                                                                                | None                    |

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|          |              |                                                                | Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.                                                       | Massachusetts dental plans. Please check with patient's medical insurer for possible coverage.                                                       |                         |
| D1706    | Preventive   | AstraZeneca COVID-19 vaccine administration – second dose      | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | None                    |
| D1707    | Preventive   | Janssen COVID-19 vaccine administration                        | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | None                    |
| D1708    | Preventive   | Pfizer-BioNTech Covid-19 vaccine administration – third dose   | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | None                    |
| D1709    | Preventive   | Pfizer-BioNTech Covid-19 vaccine administration – booster dose | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | None                    |
| D1710    | Preventive   | Moderna Covid-19 vaccine administration – third dose           | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | None                    |
| D1711    | Preventive   | Moderna Covid-19 vaccine administration – booster dose         | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | None                    |
| D1712    | Preventive   | Janssen Covid-19 vaccine administration - booster dose         | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's                                        | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's                                        | None                    |

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|          |              |                                                                                      | medical insurer for possible coverage.                                                                                                                                                                                                                             | medical insurer for possible coverage.                                                                                                                                                                                   |                                                    |
| D1713    | Preventive   | Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – first dose  | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage.                                                                                                               | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage.                                                                     | None                                               |
| D1714    | Preventive   | Pfizer-BioNTech Covid-19 vaccine administration tris-sucrose pediatric – second dose | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage.                                                                                                               | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage.                                                                     | None                                               |
| D1781    | Preventive   | Vaccine administration – human papillomavirus – Dose 1                               | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage.                                                                                                               | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage.                                                                     | None                                               |
| D1782    | Preventive   | Vaccine administration – human papillomavirus – Dose 2                               | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage.                                                                                                               | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage.                                                                     | None                                               |
| D1783    | Preventive   | Vaccine administration – human papillomavirus – Dose 3                               | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage.                                                                                                               | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient’s medical insurer for possible coverage.                                                                     | None                                               |
| D1999    | Preventive   | Unspecified preventive procedure, by report                                          | Individual consideration.                                                                                                                                                                                                                                          | Individual consideration.                                                                                                                                                                                                | Detailed narrative                                 |
| D2140    | Restorative  | Amalgam – one surface, primary or permanent                                          | One restoration per tooth surface per 12 months. Contiguous surface restorations are considered one multiple-surface restoration.<br><br>Note: Amalgam restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap, local | One restoration per tooth surface per 24 months. Contiguous surface restorations are considered one multiple-surface restoration.<br><br>Note: Amalgam restorations include tooth preparation, localized tissue removal, | Tooth identification<br><br>Surface identification |

| CDT Code | ADA Category | Description of Service                         | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Submission Requirements                                   |
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|          |              |                                                | anesthesia and all adhesives (including amalgam bonding agents, liners and bases). These are included as part of the restoration. If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.                                                                                                                                                                                                                                                                           | base, direct and indirect pulp cap, local anesthesia and all adhesives (including amalgam bonding agents, liners and bases). These are included as part of the restoration. If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.                                                                                                                                                                                                                                 |                                                           |
| D2150    | Restorative  | Amalgam – two surfaces, primary or permanent   | <p>One restoration per tooth surface per 12 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Amalgam restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap, local anesthesia and all adhesives (including amalgam bonding agents, liners and bases). These are included as part of the restoration. If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>One restoration per tooth surface per 24 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Amalgam restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap, local anesthesia and all adhesives (including amalgam bonding agents, liners and bases). These are included as part of the restoration. If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>Tooth identification</p> <p>Surface identification</p> |
| D2160    | Restorative  | Amalgam – three surfaces, primary or permanent | One restoration per tooth surface per 12 months. Contiguous surface restorations are                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | One restoration per tooth surface per 24 months. Contiguous surface restorations are considered                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | Tooth identification                                      |

| CDT Code | ADA Category | Description of Service                                | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | Submission Requirements                                   |
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|          |              |                                                       | <p>considered one multiple-surface restoration.</p> <p>Note: Amalgam restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap, local anesthesia and all adhesives (including amalgam bonding agents, liners and bases). These are included as part of the restoration. If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p>                                                                                      | <p>one multiple-surface restoration.</p> <p>Note: Amalgam restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap, local anesthesia and all adhesives (including amalgam bonding agents, liners and bases). These are included as part of the restoration. If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p>                                                              | Surface identification                                    |
| D2161    | Restorative  | Amalgam – four or more surfaces, primary or permanent | <p>One restoration per tooth surface per 12 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Amalgam restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap, local anesthesia and all adhesives (including amalgam bonding agents, liners and bases). These are included as part of the restoration. If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>One restoration per tooth surface per 24 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Amalgam restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap, local anesthesia and all adhesives (including amalgam bonding agents, liners and bases). These are included as part of the restoration. If pins are used, they should be reported separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or</p> | <p>Tooth identification</p> <p>Surface identification</p> |

| CDT Code | ADA Category | Description of Service                         | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Submission Requirements                                   |
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|          |              |                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | abrasion are not covered benefits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                           |
| D2330    | Restorative  | Resin-based composite – one surface, anterior  | <p>One restoration per tooth surface per 12 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>One restoration per tooth surface per 24 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>Tooth identification</p> <p>Surface identification</p> |
| D2331    | Restorative  | Resin-based composite – two surfaces, anterior | <p>One restoration per tooth surface per 12 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <p>One restoration per tooth surface per 24 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | <p>Tooth identification</p> <p>Surface identification</p> |

| CDT Code | ADA Category | Description of Service                           | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Submission Requirements                                   |
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|          |              |                                                  | May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits. | including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits. |                                                           |
| D2332    | Restorative  | Resin-based composite – three surfaces, anterior | <p>One restoration per tooth surface per 12 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as</p>               | <p>One restoration per tooth surface per 24 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct</p>                                                                                                                                  | <p>Tooth identification</p> <p>Surface identification</p> |

| CDT Code | ADA Category | Description of Service                                   | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Submission Requirements                                   |
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|          |              |                                                          | restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                           |
| D2335    | Restorative  | Resin-based composite – four or more surfaces (anterior) | <p>One restoration per tooth surface per 12 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>One restoration per tooth surface per 24 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or</p> | <p>Tooth identification</p> <p>Surface identification</p> |

| CDT Code | ADA Category | Description of Service                         | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Submission Requirements                                   |
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|          |              |                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | abrasion are not covered benefits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                           |
| D2390    | Restorative  | Resin-based composite crown, anterior          | <p>One per tooth per 12 months.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>One per tooth per 24 months.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>Tooth identification</p>                               |
| D2391    | Restorative  | Resin-based composite – one surface, posterior | <p>One per tooth surface per 12 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin</p>                                                                                                                                                                                                                                                                                                                            | <p>One restoration per tooth surface per 24 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and</p>                                                                                                                                                                                                                                                                                                                                                                                                          | <p>Tooth identification</p> <p>Surface identification</p> |

| CDT Code | ADA Category | Description of Service                          | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | Submission Requirements                                   |
|----------|--------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
|          |              |                                                 | restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.                                                                                                                                                                                                                                                                                                                                             | adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.                                                                                                                                   |                                                           |
| D2392    | Restorative  | Resin-based composite – two surfaces, posterior | <p>One per tooth surface per 12 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations</p> | <p>One restoration per tooth surface per 24 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If</p> | <p>Tooth identification</p> <p>Surface identification</p> |

| CDT Code | ADA Category | Description of Service                                   | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Submission Requirements                                   |
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|          |              |                                                          | for erosion, attrition, abfraction, or abrasion are not covered benefits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                           |
| D2393    | Restorative  | Resin-based composite – three surfaces, posterior        | <p>One per tooth surface per 12 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>One restoration per tooth surface per 24 months. Contiguous surface restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>Tooth identification</p> <p>Surface identification</p> |
| D2394    | Restorative  | Resin-based composite – four or more surfaces, posterior | One per tooth surface per 12 months. Contiguous surface                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | One restoration per tooth surface per 24 months. Contiguous surface                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Tooth identification                                      |

| CDT Code | ADA Category | Description of Service | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Submission Requirements                                   |
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|          |              |                        | <p>restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>restorations are considered one multiple-surface restoration.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | Surface identification                                    |
| D2410    | Restorative  | Gold foil, one surface | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <p>One restoration per tooth surface per 12 months.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include</p>                                                                                                                                                                                                                                                                                                                                                                                                             | <p>Tooth identification</p> <p>Surface identification</p> |

| CDT Code | ADA Category | Description of Service  | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Submission Requirements                                   |
|----------|--------------|-------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
|          |              |                         |                                              | tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.                                                                                                                                                                                                                                                                                                                                                                       |                                                           |
| D2420    | Restorative  | Gold foil, two surfaces | Not a covered benefit.                       | <p>One restoration per tooth surface per 12 months.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>Tooth identification</p> <p>Surface identification</p> |

| CDT Code | ADA Category | Description of Service        | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | Submission Requirements                                   |
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| D2430    | Restorative  | Gold foil, three surfaces     | Not a covered benefit.                       | <p>One restoration per tooth surface per 12 months.</p> <p>Note: Resin refers to a broad category of materials including, but not limited to composites. May include bonded composite, light-cured composite, etc. Light curing, acid-etching, and adhesives (including resin bonding agents) are included as part of the restoration. Resin restorations include tooth preparation, localized tissue removal, base, direct and indirect pulp cap and local anesthesia. Glass ionomers, when used as restorations, should be reported with these codes. If pins are used, please report them separately (see D2951). Restorations are only allowed for fracture or decay. Restorations for erosion, attrition, abfraction, or abrasion are not covered benefits.</p> | <p>Tooth identification</p> <p>Surface identification</p> |
| D2510    | Restorative  | Inlay – metallic, one surface | Not a covered benefit.                       | <p>One restoration per tooth surface per 84 months. Alternate benefit of a corresponding amalgam restoration paid for metallic inlays. The member is responsible for the balance.</p> <p>Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.</p>                                                                                                                                                                                                                                                                                                                                                                                          | <p>Tooth identification</p> <p>Surface identification</p> |

| CDT Code | ADA Category | Description of Service                   | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                       | Submission Requirements                            |
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| D2520    | Restorative  | Inlay – metallic, two surfaces           | Not a covered benefit.                       | One restoration per tooth surface per 84 months. Alternate benefit of a corresponding amalgam restoration paid for metallic inlays. The member is responsible for the balance.<br><br>Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips. | Tooth identification<br><br>Surface identification |
| D2530    | Restorative  | Inlay – metallic, three or more surfaces | Not a covered benefit.                       | One restoration per tooth surface per 84 months. Alternate benefit of a corresponding amalgam restoration paid for metallic inlays. The member is responsible for the balance.<br><br>Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips. | Tooth identification<br><br>Surface identification |
| D2542    | Restorative  | Onlay – metallic, two surfaces           | Not a covered benefit.                       | One restoration per tooth surface per 84 months. Limited to permanent posterior teeth 1-5, 12-21, 28-32.<br><br>Note: An onlay is considered to be a dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.                                                         | Tooth identification<br><br>Surface identification |
| D2543    | Restorative  | Onlay – metallic, three surfaces         | Not a covered benefit.                       | One restoration per tooth surface per 84 months. Limited to permanent                                                                                                                                                                                                                                                                                                | Tooth identification                               |

| CDT Code | ADA Category | Description of Service                            | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                  | Submission Requirements                            |
|----------|--------------|---------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
|          |              |                                                   |                                              | posterior teeth 1-5, 12-21, 28-32.<br><br>Note: An onlay is considered to be a dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.                                                                          | Surface identification                             |
| D2544    | Restorative  | Onlay – metallic, four or more surfaces           | Not a covered benefit.                       | One restoration per tooth surface per 84 months.<br>Limited to permanent posterior teeth 1-5, 12-21, 28-32.<br><br>Note: An onlay is considered to be a dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface. | Tooth identification<br><br>Surface identification |
| D2610    | Restorative  | Inlay – porcelain/ceramic, one surface            | Not a covered benefit.                       | One restoration per tooth surface per 84 months.<br><br>Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.                                                                          | Tooth identification<br><br>Surface identification |
| D2620    | Restorative  | Inlay – porcelain/ceramic, two surfaces           | Not a covered benefit.                       | One restoration per tooth surface per 84 months.<br><br>Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.                                                                          | Tooth identification<br><br>Surface identification |
| D2630    | Restorative  | Inlay – porcelain/ceramic, three or more surfaces | Not a covered benefit.                       | One restoration per tooth surface per 84 months.                                                                                                                                                                                                                                                                | Tooth identification                               |

| CDT Code | ADA Category | Description of Service                           | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                             | Submission Requirements                                   |
|----------|--------------|--------------------------------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
|          |              |                                                  |                                              | Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.                                                                                                                                             | Surface identification                                    |
| D2642    | Restorative  | Onlay – porcelain/ceramic, two surfaces          | Not a covered benefit.                       | <p>One restoration per tooth surface per 84 months.</p> <p>Limited to permanent posterior teeth 1-5, 12-21, 28-32.</p> <p>Note: An onlay is considered to be a dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.</p> | <p>Tooth identification</p> <p>Surface identification</p> |
| D2643    | Restorative  | Onlay – porcelain/ceramic, three surfaces        | Not a covered benefit.                       | <p>One restoration per tooth surface per 84 months.</p> <p>Limited to permanent posterior teeth 1-5, 12-21, 28-32.</p> <p>Note: An onlay is considered to be a dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.</p> | <p>Tooth identification</p> <p>Surface identification</p> |
| D2644    | Restorative  | Onlay – porcelain/ceramic, four or more surfaces | Not a covered benefit.                       | <p>One restoration per tooth surface per 84 months.</p> <p>Limited to permanent posterior teeth 1-5, 12-21, 28-32.</p> <p>Note: An onlay is considered to be a dental restoration made outside the oral cavity</p>                                                                                                         | <p>Tooth identification</p> <p>Surface identification</p> |

| CDT Code | ADA Category | Description of Service                                | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                       | Submission Requirements                            |
|----------|--------------|-------------------------------------------------------|----------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
|          |              |                                                       |                                              | that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.                                                                                                                                                              |                                                    |
| D2650    | Restorative  | Inlay – resin-based composite, one surface            | Not a covered benefit.                       | One restoration per tooth surface per 84 months.<br><br>Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.                               | Tooth identification<br><br>Surface identification |
| D2651    | Restorative  | Inlay – resin-based composite, two surfaces           | Not a covered benefit.                       | One restoration per tooth surface per 84 months.<br><br>Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.                               | Tooth identification<br><br>Surface identification |
| D2652    | Restorative  | Inlay – resin-based composite, three or more surfaces | Not a covered benefit.                       | One restoration per tooth surface per 84 months.<br><br>Note: an inlay is considered to be an intra-coronal dental restoration, made outside the oral cavity to conform to the prepared cavity, which does not restore any cusps tips.                               | Tooth identification<br><br>Surface identification |
| D2662    | Restorative  | Onlay – resin-based composite, two surfaces           | Not a covered benefit.                       | One restoration per tooth surface per 84 months.<br><br>Limited to permanent posterior teeth 1-5, 12-21, 28-32.<br><br>Note: An onlay is considered to be a dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal | Tooth identification<br><br>Surface identification |

| CDT Code | ADA Category | Description of Service                                 | Pediatric EHB Procedure Guidelines Ages 0-19                             | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                             | Submission Requirements                                   |
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|          |              |                                                        |                                                                          | surfaces, but not the entire external surface.                                                                                                                                                                                                                                                                             |                                                           |
| D2663    | Restorative  | Onlay – resin-based composite, three surfaces          | Not a covered benefit.                                                   | <p>One restoration per tooth surface per 84 months.</p> <p>Limited to permanent posterior teeth 1-5, 12-21, 28-32.</p> <p>Note: An onlay is considered to be a dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.</p> | <p>Tooth identification</p> <p>Surface identification</p> |
| D2664    | Restorative  | Onlay – resin-based composite, four or more surfaces   | Not a covered benefit.                                                   | <p>One restoration per tooth surface per 84 months.</p> <p>Limited to permanent posterior teeth 1-5, 12-21, 28-32.</p> <p>Note: An onlay is considered to be a dental restoration made outside the oral cavity that covers one or more cusp tips and adjoining occlusal surfaces, but not the entire external surface.</p> | <p>Tooth identification</p> <p>Surface identification</p> |
| D2710    | Restorative  | Crown – resin-based composite (indirect)               | Once per permanent tooth per 60 months for teeth numbers 3-14 and 19-30. | <p>Once per permanent tooth per 84 months for teeth numbers 3-14 and 19-30.</p> <p>Note: Subject to a six-month waiting period for members age 19 and over</p>                                                                                                                                                             | Tooth identification                                      |
| D2712    | Restorative  | Crown - $\frac{3}{4}$ resin-based composite (indirect) | Not a covered benefit.                                                   | <p>One crown or cast restoration per permanent tooth per 84 months.</p> <p>Note: Subject to a six-month waiting period for members age 19 and over</p>                                                                                                                                                                     | Tooth identification                                      |

| CDT Code | ADA Category | Description of Service                              | Pediatric EHB Procedure Guidelines Ages 0-19                   | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                  | Submission Requirements |
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| D2720    | Restorative  | Crown - resin with high noble metal                 | Not a covered benefit.                                         | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2721    | Restorative  | Crown – resin with predominantly base metal         | Not a covered benefit.                                         | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2722    | Restorative  | Crown – resin with noble metal                      | Not a covered benefit.                                         | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2740    | Restorative  | Crown – porcelain/ceramic substrate                 | Once per tooth per 60 months for teeth numbers 2-15 and 18-31. | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2750    | Restorative  | Crown – porcelain fused to high-noble metal         | Once per tooth per 60 months for teeth numbers 2-15 and 18-31. | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2751    | Restorative  | Crown – porcelain fused to predominantly base metal | Once per tooth per 60 months for teeth numbers 2-15 and 18-31. | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |

| CDT Code | ADA Category | Description of Service                                  | Pediatric EHB Procedure Guidelines Ages 0-19                   | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                  | Submission Requirements |
|----------|--------------|---------------------------------------------------------|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| D2752    | Restorative  | Crown – porcelain fused to noble metal                  | Once per tooth per 60 months for teeth numbers 2-15 and 18-31. | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2753    | Restorative  | Crown – porcelain fused to titanium and titanium alloys | Once per tooth per 60 months for teeth numbers 2-15 and 18-31. | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2780    | Restorative  | Crown – ¾ cast high noble metal                         | Not a covered benefit.                                         | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2781    | Restorative  | Crown – ¾ cast predominantly base metal                 | Not a covered benefit.                                         | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2782    | Restorative  | Crown – ¾ cast noble metal                              | Not a covered benefit.                                         | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2783    | Restorative  | Crown – ¾ porcelain/ceramic                             | Not a covered benefit.                                         | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |

| CDT Code | ADA Category | Description of Service                                                                           | Pediatric EHB Procedure Guidelines Ages 0-19                                   | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                  | Submission Requirements |
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| D2790    | Restorative  | Crown – full cast high-noble metal                                                               | Once per tooth per 60 months for teeth numbers 2-15 and 18-31.                 | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2791    | Restorative  | Crown – full cast predominantly base metal                                                       | Not a covered benefit.                                                         | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2792    | Restorative  | Crown – full cast noble metal                                                                    | Not a covered benefit.                                                         | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2794    | Restorative  | Crown – titanium and titanium alloys                                                             | Not a covered benefit.                                                         | One crown or cast restoration per permanent tooth per 84 months.<br><br>Note: Subject to a six-month waiting period for members age 19 and over | Tooth identification    |
| D2799    | Restorative  | Interim crown – further treatment or completion of diagnosis necessary prior to final impression | Not a covered benefit.                                                         | Not a covered benefit.                                                                                                                          | None                    |
| D2910    | Restorative  | Recement inlay, onlay, or partial coverage restoration                                           | One per tooth per 12 months. Not covered within 6 months of initial placement. | One per tooth per 12 months.<br><br>Not covered within 6 months of initial placement.                                                           | Tooth identification    |
| D2915    | Restorative  | Recement cast or prefabricated post and core                                                     | Not a covered benefit.                                                         | One per tooth per 12 months.<br><br>Not covered within 6 months of initial placement.                                                           | Tooth identification    |
| D2920    | Restorative  | Recement crown                                                                                   | Once per tooth per 12 months.                                                  | Not covered within 6 months of initial placement.                                                                                               | Tooth identification    |

| CDT Code | ADA Category | Description of Service                                              | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                    | Submission Requirements |
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| D2921    | Restorative  | Reattachment of tooth fragment, incisal edge, or cusp               | Not a covered benefit.                                                                                                                       | Not a covered benefit.                                                                                                                                                                                                                                                            | None                    |
| D2928    | Restorative  | Prefabricated porcelain/ceramic crown – permanent tooth             | Not a covered benefit.                                                                                                                       | Not a covered benefit.                                                                                                                                                                                                                                                            | None                    |
| D2929    | Restorative  | Prefabricated porcelain/ceramic crown – primary tooth               | Not a covered benefit.                                                                                                                       | Not a covered benefit.                                                                                                                                                                                                                                                            | None                    |
| D2930    | Restorative  | Prefabricated stainless steel crown – primary tooth                 | One per tooth per 12 months. Maximum of four crowns per date of service.                                                                     | One per tooth per 24 months.                                                                                                                                                                                                                                                      | Tooth identification    |
| D2931    | Restorative  | Prefabricated stainless steel crown – permanent tooth               | One per tooth per 12 months. Maximum of four crowns per date of service. Limited to permanent posterior teeth (#2-5, 12-15, 18-21 and 28-31. | Not a covered benefit.                                                                                                                                                                                                                                                            | Tooth identification    |
| D2932    | Restorative  | Prefabricated resin crown                                           | One per tooth per 12 months. Maximum of four crowns per date of service.                                                                     | Not a covered benefit.                                                                                                                                                                                                                                                            | Tooth identification    |
| D2933    | Restorative  | Prefabricated stainless steel crown with resin window               | Not a covered benefit.                                                                                                                       | Not a covered benefit.                                                                                                                                                                                                                                                            | None                    |
| D2934    | Restorative  | Prefabricated esthetic coated stainless steel crown – primary tooth | One per tooth per 12 months. Maximum of four crowns per date of service.                                                                     | One per tooth per 24 months.                                                                                                                                                                                                                                                      | Tooth identification    |
| D2940    | Restorative  | Placement of interim direct restoration                             | Not a covered benefit.                                                                                                                       | One per tooth per lifetime. Direct placement of a temporary restorative material to protect tooth and/or tissue form. May be used to relieve pain, promote healing, or prevent further deterioration. Should not be reported as a base or in conjunction with other restorations. | Tooth identification    |
| D2949    | Restorative  | Restorative foundation for an indirect restoration                  | Not a covered benefit.                                                                                                                       | Not a covered benefit.                                                                                                                                                                                                                                                            | None                    |
| D2950    | Restorative  | Core buildup, including any pins when required                      | Not a covered benefit.                                                                                                                       | Once per permanent tooth per 84 months.                                                                                                                                                                                                                                           | Tooth identification    |
| D2951    | Restorative  | Pin retention – per tooth, in addition to restoration               | Covered when billed with a two or more surface restoration on a permanent tooth only.                                                        | Limited to three pins per tooth per lifetime.                                                                                                                                                                                                                                     | Tooth identification    |
| D2952    | Restorative  | Post and core in addition to crown, indirectly fabricated           | Not a covered benefit.                                                                                                                       | Once per tooth per 84 months.                                                                                                                                                                                                                                                     | Tooth identification    |
| D2953    | Restorative  | Each additional indirectly fabricated post – same tooth             | Not a covered benefit.                                                                                                                       | Once per tooth per lifetime.                                                                                                                                                                                                                                                      | Tooth identification    |

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| D2954    | Restorative  | Prefabricated post and core in addition to crown                                                                                            | Once per tooth per 60 months for teeth numbers 2-15 and 18-31.                                  | Once per tooth per 84 months.                                                                   | Tooth identification                       |
| D2955    | Restorative  | Post removal                                                                                                                                | Not a covered benefit.                                                                          | Not a covered benefit.                                                                          | None                                       |
| D2956    | Restorative  | Removal of an indirect restoration on a natural tooth                                                                                       | Not a covered benefit.                                                                          | Not a covered benefit.                                                                          | None                                       |
| D2957    | Restorative  | Each additional prefabricated post – same tooth                                                                                             | Not a covered benefit.                                                                          | Once per tooth per lifetime. Limited to teeth 1-5, 12-21 and 28-32                              | Tooth identification                       |
| D2960    | Restorative  | Labial veneer (resin laminate) – direct                                                                                                     | Not a covered benefit.                                                                          | Not a covered benefit.                                                                          | None                                       |
| D2961    | Restorative  | Labial veneer (resin laminate) – indirect                                                                                                   | Not a covered benefit.                                                                          | Not a covered benefit.                                                                          | None                                       |
| D2962    | Restorative  | Labial veneer (porcelain laminate) – indirect                                                                                               | Not a covered benefit.                                                                          | Not a covered benefit.                                                                          | None                                       |
| D2971    | Restorative  | Additional procedures to customize a crown to fit under an existing partial denture framework                                               | Not a covered benefit.                                                                          | Individual consideration.                                                                       | Tooth identification<br>Detailed narrative |
| D2975    | Restorative  | Coping a thin covering of the coronal portion of the tooth. Usually devoid of anatomic contour that can be used as a definitive restoration | Not a covered benefit.                                                                          | Not a covered benefit.                                                                          | None                                       |
| D2976    | Restorative  | Band stabilization – per tooth                                                                                                              | Not a covered benefit.                                                                          | Not a covered benefit.                                                                          | None                                       |
| D2980    | Restorative  | Crown repair necessitated by restorative material failure                                                                                   | Covered benefit.                                                                                | One per tooth per 12 months.                                                                    | Tooth identification<br>Detailed narrative |
| D2981    | Restorative  | Inlay repair necessitated by restorative material failure                                                                                   | Not a covered benefit.                                                                          | Once per tooth per 12 months.                                                                   | Tooth identification                       |
| D2982    | Restorative  | Onlay repair necessitated by restorative material failure                                                                                   | Not a covered benefit.                                                                          | Once per tooth per 12 months.                                                                   | Tooth identification                       |
| D2983    | Restorative  | Veneer repair necessitated by restorative material failure                                                                                  | Not a covered benefit.                                                                          | Not a covered benefit.                                                                          | None                                       |
| D2989    | Restorative  | Excavation of a tooth resulting in the determination of non-restorability                                                                   | Not a covered benefit.                                                                          | Not a covered benefit.                                                                          | None                                       |
| D2990    | Restorative  | Resin infiltration of incipient smooth surface lesions                                                                                      | Not a covered benefit.                                                                          | Once per tooth per 12 months.                                                                   | Tooth identification                       |
| D2991    | Restorative  | Application of hydroxyapatite regeneration medicament – per tooth                                                                           | Not a covered benefit.                                                                          | Not a covered benefit.                                                                          | None                                       |
| D2999    | Restorative  | Unspecified restorative procedure, by report                                                                                                | Individual consideration.                                                                       | Individual consideration.                                                                       | Detailed narrative                         |
| D3110    | Endodontics  | Pulp cap – direct (excluding final restoration)                                                                                             | Considered inclusive of the final restoration. Not a covered benefit in any other circumstance. | Considered inclusive of the final restoration. Not a covered benefit in any other circumstance. | Tooth identification                       |
| D3120    | Endodontics  | Pulp cap – indirect (excluding final restoration)                                                                                           | Considered inclusive of the final restoration. Not a covered                                    | Considered inclusive of the final restoration. Not a                                            | Tooth identification                       |

| CDT Code | ADA Category | Description of Service                                                                                                                      | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                              | Adult EHB Procedure Guidelines Ages 19 & older                                                                                            | Submission Requirements                                                                     |
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|          |              |                                                                                                                                             | benefit in any other circumstance.                                                                                                        | covered benefit in any other circumstance.                                                                                                |                                                                                             |
| D3220    | Endodontics  | Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament | One per tooth per lifetime. Part of endodontic therapy when performed by the same dentist.                                                | One per tooth per lifetime. Part of endodontic therapy when performed by the same dentist.                                                | Tooth identification                                                                        |
| D3221    | Endodontics  | Pulpal debridement, primary & permanent teeth                                                                                               | Not a covered benefit.                                                                                                                    | Once per tooth per lifetime.                                                                                                              | Tooth identification                                                                        |
| D3222    | Endodontics  | Partial pulpotomy for apexogenesis – permanent tooth with incomplete root development.                                                      | Not a covered benefit.                                                                                                                    | Once per tooth per lifetime.                                                                                                              | None                                                                                        |
| D3230    | Endodontics  | Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)                                                 | Not a covered benefit.                                                                                                                    | Once per tooth per lifetime.                                                                                                              | None                                                                                        |
| D3240    | Endodontics  | Pulpal therapy (resorbable filling) – posterior primary tooth (excluding final restoration)                                                 | Not a covered benefit.                                                                                                                    | Once per tooth per lifetime.                                                                                                              | None                                                                                        |
| D3310    | Endodontics  | Endodontic therapy, anterior tooth (excluding final restoration)                                                                            | One per permanent tooth per lifetime.<br><br>Note: includes treatment plan, clinical procedures and follow-up care                        | One per permanent tooth per lifetime.<br><br>Note: includes treatment plan, clinical procedures and follow-up care                        | Tooth identification                                                                        |
| D3320    | Endodontics  | Endodontic therapy, premolar tooth (excluding final restoration)                                                                            | One per permanent tooth per lifetime excluding third molars.<br><br>Note: includes treatment plan, clinical procedures and follow-up care | One per permanent tooth per lifetime excluding third molars.<br><br>Note: includes treatment plan, clinical procedures and follow-up care | Tooth identification                                                                        |
| D3330    | Endodontics  | Endodontic therapy, molar (excluding final restoration)                                                                                     | One per permanent tooth per lifetime excluding third molars.<br><br>Note: includes treatment plan, clinical procedures and follow-up care | One per permanent tooth per lifetime excluding third molars.<br><br>Note: includes treatment plan, clinical procedures and follow-up care | Tooth identification                                                                        |
| D3331    | Endodontics  | Treatment of root canal obstruction; non-surgical access                                                                                    | Not a covered benefit.                                                                                                                    | Individual consideration.                                                                                                                 | Tooth identification<br><br>Detailed narrative<br><br>Current dated pre- and post-operative |

| CDT Code | ADA Category | Description of Service                                                                                                                                         | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                           | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                         | Submission Requirements |
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|          |              |                                                                                                                                                                |                                                                                                                                                                                        |                                                                                                                                                                                        | periapical radiographs  |
| D3332    | Endodontics  | Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth                                                                                     | Not a covered benefit.                                                                                                                                                                 | Not a covered benefit.                                                                                                                                                                 | None                    |
| D3333    | Endodontics  | Internal root repair of perforation defects                                                                                                                    | Not a covered benefit.                                                                                                                                                                 | Not a covered benefit.                                                                                                                                                                 | None                    |
| D3346    | Endodontics  | Retreatment of previous root canal therapy – anterior                                                                                                          | One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months. | One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months. | Tooth identification    |
| D3347    | Endodontics  | Retreatment of previous root canal therapy – premolar                                                                                                          | One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months. | One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months. | Tooth identification    |
| D3348    | Endodontics  | Retreatment of previous root canal therapy – molar                                                                                                             | One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months. | One per permanent tooth per lifetime excluding third molars. Coverage is considered when prior root canal failed and re-treatment is performed by another dentist or within 24 months. | Tooth identification    |
| D3351    | Endodontics  | Apexification / recalcification – initial visit (apical closure/calcalcific repair of perforations, root resorption, pulp space disinfection, etc).            | Not a covered benefit.                                                                                                                                                                 | Once per permanent tooth per lifetime.                                                                                                                                                 | Tooth identification    |
| D3352    | Endodontics  | Apexification / recalcification – interim medication replacement                                                                                               | Not a covered benefit.                                                                                                                                                                 | Once per permanent tooth per lifetime.                                                                                                                                                 | Tooth identification    |
| D3353    | Endodontics  | Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcalcific repair of perforations, root resorption, etc.) | Not a covered benefit.                                                                                                                                                                 | Once per permanent tooth per lifetime.                                                                                                                                                 | Tooth identification    |
| D3355    | Endodontics  | Pulpal regeneration – initial visit                                                                                                                            | Not a covered benefit.                                                                                                                                                                 | Once per permanent tooth per lifetime.                                                                                                                                                 | Tooth identification    |
| D3356    | Endodontics  | Pulpal regeneration – interim medication replacement                                                                                                           | Not a covered benefit.                                                                                                                                                                 | Once per permanent tooth per lifetime.                                                                                                                                                 | Tooth identification    |
| D3357    | Endodontics  | Pulpal regeneration – completion of treatment                                                                                                                  | Not a covered benefit.                                                                                                                                                                 | Once per permanent tooth per lifetime.                                                                                                                                                 | Tooth identification    |

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| D3410    | Endodontics  | Apicoectomy – anterior                                                                                      | One per permanent tooth root per lifetime.   | Once per permanent tooth root per lifetime.                                                         | Tooth and root identification |
| D3421    | Endodontics  | Apicoectomy – premolar (first root)                                                                         | One per permanent tooth root per lifetime.   | Once per permanent tooth root per lifetime.                                                         | Tooth and root identification |
| D3425    | Endodontics  | Apicoectomy – molar (first root)                                                                            | One per permanent tooth root per lifetime.   | Once per permanent tooth root per lifetime.                                                         | Tooth and root identification |
| D3426    | Endodontics  | Apicoectomy – each additional                                                                               | One per permanent tooth root per lifetime.   | Once per permanent tooth root per lifetime.                                                         | Tooth and root identification |
| D3428    | Endodontics  | Bone graft in conjunction with periradicular surgery – per tooth, single site                               | Not a covered benefit.                       | Not a covered benefit.                                                                              | None                          |
| D3429    | Endodontics  | Bone graft in conjunction with periradicular surgery – each additional contiguous in the same surgical site | Not a covered benefit.                       | Not a covered benefit.                                                                              | None                          |
| D3430    | Endodontics  | Retrograde filling – per root                                                                               | Not a covered benefit.                       | Once per permanent tooth per lifetime.                                                              | Tooth and root identification |
| D3431    | Endodontics  | Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery | Not a covered benefit.                       | Not a covered benefit.                                                                              | None                          |
| D3432    | Endodontics  | Guided tissue regeneration, resorbable barrier, per site, in conjunction with periradicular surgery         | Not a covered benefit.                       | Not a covered benefit.                                                                              | None                          |
| D3450    | Endodontics  | Root amputation – per root                                                                                  | Not a covered benefit.                       | One per tooth per lifetime for multi-rooted posterior teeth.                                        | Tooth and root identification |
| D3460    | Endodontics  | Endodontic endosseous implant                                                                               | Not a covered benefit.                       | Not a covered benefit.                                                                              | None                          |
| D3470    | Endodontics  | Intentional reimplantation (including necessary splinting)                                                  | Not a covered benefit.                       | Individual consideration.                                                                           | Detailed narrative            |
| D3471    | Endodontics  | Surgical repair of root resorption – anterior                                                               | Not a covered benefit.                       | One per tooth root per lifetime. Considered inclusive if submitted with D3410, D3421, D3425, D3426. | Tooth and root identification |
| D3472    | Endodontics  | Surgical repair of root resorption – premolar                                                               | Not a covered benefit.                       | One per tooth root per lifetime. Considered inclusive if submitted with D3410, D3421, D3425, D3426. | Tooth and root identification |
| D3473    | Endodontics  | Surgical repair of root resorption – molar                                                                  | Not a covered benefit.                       | One per tooth root per lifetime. Considered inclusive if submitted with D3410, D3421, D3425, D3426. | Tooth and root identification |
| D3501    | Endodontics  | Surgical repair of root surface without apicoectomy or repair of root resorption – anterior                 | Not a covered benefit.                       | Not a covered benefit.                                                                              | None                          |

| CDT Code | ADA Category | Description of Service                                                                              | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                              | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                          | Submission Requirements                                                                                                                                                                                                                                                        |
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| D3502    | Endodontics  | Surgical repair of root surface without apicoectomy or repair of root resorption – premolar         | Not a covered benefit.                                                                                                                    | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | None                                                                                                                                                                                                                                                                           |
| D3503    | Endodontics  | Surgical repair of root surface without apicoectomy or repair of root resorption – molar            | Not a covered benefit.                                                                                                                    | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | None                                                                                                                                                                                                                                                                           |
| D3910    | Endodontics  | Surgical procedure for isolation of tooth with rubber dam                                           | Not a covered benefit.                                                                                                                    | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | None                                                                                                                                                                                                                                                                           |
| D3911    | Endodontics  | Intraorifice barrier                                                                                | Not a covered benefit.                                                                                                                    | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | None                                                                                                                                                                                                                                                                           |
| D3920    | Endodontics  | Hemisection (including any root removal), not including root canal therapy                          | Not a covered benefit.                                                                                                                    | One per posterior tooth per lifetime.                                                                                                                                                                                                                                                                                                                                                                                                                                                   | Tooth identification                                                                                                                                                                                                                                                           |
| D3921    | Endodontics  | Decoronation or submergence of an erupted tooth                                                     | Not a covered benefit.                                                                                                                    | One per tooth per lifetime (D3921 or D7251).                                                                                                                                                                                                                                                                                                                                                                                                                                            | Tooth identification                                                                                                                                                                                                                                                           |
| D3950    | Endodontics  | Canal preparation and fitting of preformed dowel or post                                            | Not a covered benefit.                                                                                                                    | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | None                                                                                                                                                                                                                                                                           |
| D3999    | Endodontics  | Unspecified endodontic procedure, by report                                                         | Not a covered benefit.                                                                                                                    | Individual consideration.                                                                                                                                                                                                                                                                                                                                                                                                                                                               | Tooth identification<br>Detailed narrative<br>Current dated pre- and post-operative periapical radiographs                                                                                                                                                                     |
| D4210    | Periodontics | Gingivectomy or gingivoplasty – four or more contiguous teeth or tooth-bounded spaces, per quadrant | One per quadrant per 36 months. Limited to two quadrants on the same date of service.<br><br>Note: Includes usual post-operative services | One per quadrant per 36 months. An evaluation period of ≥ 21 days to assess tissue response must be observed following scaling and root planning before benefits become available for soft tissue procedures. A gingivectomy procedure is unusual in the presence of infrabony defects.<br><br>If reported at any time in preparation and/or temporization phase of teeth for, or in association with restoration/ prostheses, D4210 is considered to be included as part of the global | Current dated post-Phase I periodontal charting<br><br>Quadrant identification<br><br>Current mounted and dated preoperative periapical radiographs. If a current full mouth set of radiographs is not available, submit current (within last year) bitewing and/or periapical |

| CDT Code | ADA Category | Description of Service                                                                                                | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                              | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                     | Submission Requirements                                           |
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|          |              |                                                                                                                       |                                                                                                                                           | restorative/prosthetic procedure.<br><br>Note: Includes usual post-operative services                                                                                                                                                                                                                                              | radiographs of the treated area)<br><br>Pre-treatment recommended |
| D4211    | Periodontics | Gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per quadrant                    | One per quadrant per 36 months. Limited to two quadrants on the same date of service.<br><br>Note: Includes usual post-operative services | One to three teeth per quadrant per 36 months. If reported at any time in preparation and/or temporization phase of tooth for, or in association with restoration/ prostheses, the D4211 is considered to be included as part of the global restorative/ prosthetic procedure.<br><br>Note: Includes usual post-operative services | Quadrant identification                                           |
| D4212    | Periodontics | Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth                                    | Not a covered benefit.                                                                                                                    | Once per quadrant per 36 months.<br><br>Note: Includes usual post-operative services                                                                                                                                                                                                                                               | Tooth identification                                              |
| D4230    | Periodontics | Anatomical crown exposure – four or more contiguous teeth or tooth-bounded spaces per quadrant                        | Not a covered benefit.                                                                                                                    | Not a covered benefit.                                                                                                                                                                                                                                                                                                             | None                                                              |
| D4231    | Periodontics | Anatomical crown exposure – one to three teeth or tooth-bounded spaces per quadrant                                   | Not a covered benefit.                                                                                                                    | Not a covered benefit.                                                                                                                                                                                                                                                                                                             | None                                                              |
| D4240    | Periodontics | Gingival flap procedure, including root planning – four or more contiguous teeth or tooth-bounded spaces per quadrant | Not a covered benefit.                                                                                                                    | Once per quadrant per 36 months.<br><br>Note: Includes usual post-operative services                                                                                                                                                                                                                                               | Quadrant identification                                           |
| D4241    | Periodontics | Gingival flap procedure, including root planning – one to three contiguous teeth or tooth-bounded spaces per quadrant | Not a covered benefit.                                                                                                                    | Once per quadrant per 36 months.<br><br>Note: Includes usual post-operative services                                                                                                                                                                                                                                               | Quadrant identification                                           |
| D4245    | Periodontics | Apically repositioned flap                                                                                            | Not a covered benefit.                                                                                                                    | Not a covered benefit.                                                                                                                                                                                                                                                                                                             | None                                                              |
| D4249    | Periodontics | Clinical crown lengthening – hard tissue. This procedure is employed to allow a restorative procedure on a tooth with | Not a covered benefit.                                                                                                                    | One per tooth per 60 months.                                                                                                                                                                                                                                                                                                       | Tooth identification                                              |

| CDT Code | ADA Category | Description of Service                                                                                                                          | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                                                                                   | Submission Requirements                                                                                                                                                                                                                                                                                                                                 |
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|          |              | little or no tooth structure exposed to the oral cavity.                                                                                        |                                              | Note: Includes usual post-operative services                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                                                                                                                                                                                                                                                                                         |
| D4260    | Periodontics | Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth-bounded spaces per quadrant | Not a covered benefit.                       | One per quadrant per 36 months. A waiting period of $\geq 28$ days should follow periodontal scaling and root planning in order to allow healing and observation of tissue response. If scaling and root planning are performed on the same date and in the same quadrant as periodontal surgery, no payment will be made for D4341 or D4342. Laser Assisted New Attachment Procedures (LANAP) is not a covered benefit and should not be submitted using Osseous surgery codes. | <p>Quadrant identification</p> <p>Current dated post phase I periodontal charting</p> <p>Current mounted and dated pre-operative periapical radiographs. If a current full mouth set of radiographs is not available, submit current (within last year) bitewing and/or periapical radiographs of the treated area</p> <p>Pre-treatment recommended</p> |
| D4261    | Periodontics | Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant | Not a covered benefit.                       | One per quadrant per 36 months. A waiting period of $\geq 28$ days should follow periodontal scaling and root planning in order to allow healing and observation of tissue response. If scaling and root planning are performed on the same date and in the same quadrant as periodontal surgery, no payment will be made for D4341 or D4342. Laser Assisted New Attachment Procedures (LANAP) is not a covered benefit and should not be                                        | <p>Quadrant identification</p> <p>Current dated post phase I periodontal charting</p> <p>Current mounted and dated pre-operative periapical radiographs. If a current full mouth set of radiographs is not available,</p>                                                                                                                               |

| CDT Code | ADA Category | Description of Service                                                      | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                           | Submission Requirements                                                                                                                                                      |
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|          |              |                                                                             |                                              | submitted using Osseous surgery codes.                                                                                                                                                                                                                                                                                                                                                   | submit current (within last year) bitewing and/or periapical radiographs of the treated area<br><br>Pre-treatment recommended                                                |
| D4263    | Periodontics | Bone replacement graft – first site in quadrant                             | Not a covered benefit.                       | One per site/tooth per 36 months. An allowance will be made in addition to the surgical procedure to cover the cost of the graft material. Not covered when used in an edentulous space, extraction site or with routine apicoectomy, cystectomy, sinus augmentation, ridge augmentation, mucogingival grafts, or implant procedure.<br><br>Note: Includes usual post-operative services | Tooth identification (edentulous spaces do not qualify for this code)<br><br>Current mounted and dated pre-operative periapical radiographs<br><br>Pre-treatment recommended |
| D4264    | Periodontics | Bone replacement graft – each additional site in quadrant                   | Not a covered benefit.                       | One per site/tooth per 36 months. An allowance will be made in addition to the surgical procedure to cover the cost of the graft material. Not covered when used in an edentulous space, extraction site or with routine apicoectomy, cystectomy, sinus augmentation, ridge augmentation, mucogingival grafts, or implant procedure.<br><br>Note: Includes usual post-operative services | Tooth identification (edentulous spaces do not qualify for this code)<br><br>Current mounted and dated pre-operative periapical radiographs<br><br>Pre-treatment recommended |
| D4265    | Periodontics | Biologic materials to aid in soft and osseous tissue regeneration, per site | Not a covered benefit.                       | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                                                   | None                                                                                                                                                                         |
| D4266    | Periodontics | Guided tissue regeneration, natural teeth – resorbable barrier, per site    | Not a covered benefit.                       | One per site/tooth per 36 months. An allowance will be                                                                                                                                                                                                                                                                                                                                   | Tooth identification                                                                                                                                                         |

| CDT Code | ADA Category | Description of Service                                                                                                                                   | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                        | Submission Requirements                                                                                                                                                      |
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|          |              |                                                                                                                                                          |                                              | made in addition to the surgical procedure to cover the cost of the graft material. Not covered when used in an edentulous space, extraction site, or with routine apicoectomy, cystectomy, ridge augmentation, mucogingival grafts, or implant procedure.<br><br>Note: Includes usual post-operative services                                                        | (edentulous spaces do not qualify for this code)<br><br>Current mounted and dated pre-operative periapical radiographs<br><br>Pre-treatment recommended                      |
| D4267    | Periodontics | Guided tissue regeneration, natural teeth – non-restorable barrier, per site                                                                             | Not a covered benefit.                       | One per site/tooth per 36 months. An allowance will be made in addition to the surgical procedure to cover the cost of the graft material. Not covered when used in an edentulous space, extraction site, or with routine apicoectomy, cystectomy, ridge augmentation, mucogingival grafts, or implant procedure.<br><br>Note: Includes usual post-operative services | Tooth identification (edentulous spaces do not qualify for this code)<br><br>Current mounted and dated pre-operative periapical radiographs<br><br>Pre-treatment recommended |
| D4268    | Periodontics | Surgical revision procedure, per tooth                                                                                                                   | Not a covered benefit.                       | Not a covered benefit.                                                                                                                                                                                                                                                                                                                                                | None                                                                                                                                                                         |
| D4270    | Periodontics | Pedicle soft tissue graft procedure                                                                                                                      | Not a covered benefit.                       | Once per tooth per 36 months. Grafting for cosmetic purposes is non-covered.<br><br>Note: Includes usual post-operative services                                                                                                                                                                                                                                      | Tooth identification                                                                                                                                                         |
| D4273    | Periodontics | Autogenous connective tissue graft procedures (including donor and recipient surgical sites) first tooth, implant, or edentulous tooth position in graft | Not a covered benefit.                       | One per site per 36 months on natural teeth only. Limited to three teeth per graft site.<br><br>Note: Includes usual post-operative services                                                                                                                                                                                                                          | Tooth identification                                                                                                                                                         |

| CDT Code | ADA Category | Description of Service                                                                                                                                                                              | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                               | Submission Requirements |
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| D4274    | Periodontics | Mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)                                                                | Not a covered benefit.                       | One per site per 36 months. Must be adjacent to edentulous area.<br><br>Note: Includes usual post-operative services                         | Tooth identification    |
| D4275    | Periodontics | Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft                                                    | Not a covered benefit.                       | One per site per 36 months on natural teeth only. Limited to three teeth per graft site.<br><br>Note: Includes usual post-operative services | Tooth identification    |
| D4276    | Periodontics | Combined connective tissue and pedicle graft, per tooth                                                                                                                                             | Not a covered benefit.                       | One per tooth per 36 months. Grafting for cosmetic purposes is non-covered.<br><br>Note: Includes usual post-operative services              | Tooth identification    |
| D4277    | Periodontics | Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft                                                          | Not a covered benefit.                       | One per site per 36 months on natural teeth only. Limited to three teeth per graft site.<br><br>Note: Includes usual post-operative services | Tooth identification    |
| D4278    | Periodontics | Free soft tissue graft procedure (including recipient and donor surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site                          | Not a covered benefit.                       | One per site per 36 months on natural teeth only. Limited to three teeth per graft site.<br><br>Note: Includes usual post-operative services | Tooth identification    |
| D4283    | Periodontics | Autogenous connective tissue graft procedure (including donor and recipient surgical sites), each additional contiguous tooth, implant or edentulous tooth position in same graft site              | Not a covered benefit.                       | Each additional tooth, up to three teeth total in graft.<br><br>Note: Includes usual post-operative services                                 | Tooth identification    |
| D4285    | Periodontics | Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) – each additional contiguous tooth, implant or edentulous tooth position in same graft site | Not a covered benefit.                       | Each additional tooth, up to three teeth total in graft.<br><br>Note: Includes usual post-operative services                                 | Tooth identification    |
| D4286    | Periodontics | Removal of non-resorbable barrier                                                                                                                                                                   | Not a covered benefit.                       | Considered inclusive of D4267, not a covered benefit in any other circumstance.                                                              | Tooth identification    |

| CDT Code | ADA Category | Description of Service                                                                                                 | Pediatric EHB Procedure Guidelines Ages 0-19                                             | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                  | Submission Requirements                                            |
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|          |              |                                                                                                                        |                                                                                          | Note: Includes usual post-operative services                                                                                                                                                                                                                                                    |                                                                    |
| D4322    | Periodontics | Splint – intra-coronal; natural teeth or prosthetic crowns                                                             | Not a covered benefit.                                                                   | Not a covered benefit.                                                                                                                                                                                                                                                                          | None                                                               |
| D4323    | Periodontics | Splint – extra-coronal; natural teeth or prosthetic crowns                                                             | Not a covered benefit.                                                                   | Not a covered benefit.                                                                                                                                                                                                                                                                          | None                                                               |
| D4341    | Periodontics | Periodontal scaling and root planning – four or more teeth per quadrant                                                | One per quadrant per 36 months.                                                          | One per quadrant per 24 months.                                                                                                                                                                                                                                                                 | Quadrant identification                                            |
| D4342    | Periodontics | Periodontal scaling and root planning, one to three teeth per quadrant                                                 | One per quadrant per 36 months.                                                          | One per quadrant per 24 months.                                                                                                                                                                                                                                                                 | Quadrant identification                                            |
| D4346    | Periodontics | Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth                           | Covered interchangeably with D1110. Held to the same frequencies and allowable as D1110. | Covered interchangeably with D1110. Held to the same frequencies and allowable as D1110.                                                                                                                                                                                                        | None                                                               |
| D4355    | Periodontics | Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit            | Not a covered benefit.                                                                   | Not a covered benefit.                                                                                                                                                                                                                                                                          | None                                                               |
| D4381    | Periodontics | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth | Not a covered benefit.                                                                   | One treatment per tooth per 24 months. Up to 2 teeth per quadrant with 5-6 mm pocket depths and bleeding on probing, subsequent to active and maintained non surgical periodontal treatment. Should not be used to treat generalized disease. Not covered for treatment of periodontal abscess. | Detailed narrative<br>Periodontal charting<br>Tooth identification |
| D4910    | Periodontics | Periodontal maintenance                                                                                                | Not a covered benefit.                                                                   | One per 3 months following active periodontal treatment. There must be at least three months between a periodontal maintenance cleaning and any other cleanings. D4910 is considered inclusive of D4341 and D4342 when performed on the same day.                                               | None                                                               |
| D4920    | Periodontics | Unscheduled dressing change (by someone other than treating dentist or their staff)                                    | Not a covered benefit                                                                    | Not a covered benefit.                                                                                                                                                                                                                                                                          | None                                                               |

| CDT Code | ADA Category               | Description of Service                                                                                                                | Pediatric EHB Procedure Guidelines Ages 0-19                                 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                            | Submission Requirements |
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| D4921    | Periodontics               | Gingival irrigation with a medicinal agent – per quadrant                                                                             | Not a covered benefit                                                        | Not a covered benefit.                                                                                                                                                    | None                    |
| D4999    | Periodontics               | Unspecified periodontal procedure, by report                                                                                          | Individual consideration.                                                    | Individual consideration.                                                                                                                                                 | Detailed narrative      |
| D5110    | Prosthodontics (removable) | Complete denture – maxillary                                                                                                          | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care | One per arch per 84 months; not covered if D5130, D5211, D5213, D5221, D5223, D5225, or D5227 was done within 84 months.<br><br>Note: Includes routine post-delivery care | Arch identification     |
| D5120    | Prosthodontics (removable) | Complete denture – mandibular                                                                                                         | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care | One per arch per 84 months; not covered if D5140, D5212, D5214, D5222, D5224, D5226, or D5228 was done within 84 months.<br><br>Note: Includes routine post-delivery care | Arch identification     |
| D5130    | Prosthodontics (removable) | Immediate denture – maxillary                                                                                                         | One per arch per lifetime.<br><br>Note: Includes routine post-delivery care  | One per arch per lifetime.<br><br>Note: Includes routine post-delivery care                                                                                               | Arch identification     |
| D5140    | Prosthodontics (removable) | Immediate denture – mandibular                                                                                                        | One per arch per lifetime.<br><br>Note: Includes routine post-delivery care  | One per arch per lifetime.<br><br>Note: Includes routine post-delivery care                                                                                               | Arch identification     |
| D5211    | Prosthodontics (removable) | Maxillary partial denture – resin base (including retentive/clasping materials, rests, and teeth)                                     | One per 84 months.<br><br>Note: Includes routine post-delivery care          | One per 84 months.<br><br>Note: Includes routine post-delivery care                                                                                                       | Arch identification     |
| D5212    | Prosthodontics (removable) | Mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)                                    | One per 84 months.<br><br>Note: Includes routine post-delivery care          | One per 84 months.<br><br>Note: Includes routine post-delivery care                                                                                                       | Arch identification     |
| D5213    | Prosthodontics (removable) | Maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)  | One per 84 months.<br><br>Note: Includes routine post-delivery care          | One per 84 months.<br><br>Note: Includes routine post-delivery care                                                                                                       | Arch identification     |
| D5214    | Prosthodontics (removable) | Mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) | One per 84 months.<br><br>Note: Includes routine post-delivery care          | One per 84 months.<br><br>Note: Includes routine post-delivery care                                                                                                       | Arch identification     |

| CDT Code | ADA Category               | Description of Service                                                                                                                          | Pediatric EHB Procedure Guidelines Ages 0-19                                                     | Adult EHB Procedure Guidelines Ages 19 & older                               | Submission Requirements |
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| D5221    | Prosthodontics (removable) | Immediate maxillary partial denture – resin base (including retentive/ clasping materials, rests, and teeth)                                    | One per arch per 84 months for members age 16+.<br><br>Note: Includes routine post-delivery care | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care | Arch identification     |
| D5222    | Prosthodontics (removable) | Immediate mandibular partial denture – resin base (including retentive/clasping materials, rests, and teeth)                                    | One per arch per 84 months for members age 16+.<br><br>Note: Includes routine post-delivery care | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care | Arch identification     |
| D5223    | Prosthodontics (removable) | Immediate maxillary partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)  | One per arch per 84 months for members age 16+.<br><br>Note: Includes routine post-delivery care | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care | Arch identification     |
| D5224    | Prosthodontics (removable) | Immediate mandibular partial denture – cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth) | One per arch per 84 months for members age 16+.<br><br>Note: Includes routine post-delivery care | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care | Arch identification     |
| D5225    | Prosthodontics (removable) | Maxillary partial denture – flexible base (including retentive/clasping materials, rests, and teeth)                                            | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care                     | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care | Arch identification     |
| D5226    | Prosthodontics (removable) | Mandibular partial denture – flexible base (including retentive/clasping materials, rests, and teeth)                                           | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care                     | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care | Arch identification     |
| D5227    | Prosthodontics (removable) | Immediate maxillary partial denture – flexible base (including any clasps, rests and teeth)                                                     | One per arch per 84 months for members age 16+.<br><br>Note: Includes routine post-delivery care | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care | Arch identification     |
| D5228    | Prosthodontics (removable) | Immediate mandibular partial denture – flexible base (including any clasps, rests and teeth)                                                    | One per arch per 84 months for members age 16+.<br><br>Note: Includes routine post-delivery care | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care | Arch identification     |
| D5282    | Prosthodontics (removable) | Removable unilateral partial denture – one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary               | Not a covered benefit.                                                                           | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care | Arch identification     |
| D5283    | Prosthodontics (removable) | Removable unilateral partial denture – one piece cast metal (including                                                                          | Not a covered benefit.                                                                           | One per arch per 84 months.                                                  | Arch identification     |

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|          |                            | retentive/clasping materials, rests, and teeth), mandibular                                                                             |                                                                      | Note: Includes routine post-delivery care                                                                                      |                         |
| D5284    | Prosthodontics (removable) | Removable unilateral partial denture – one piece flexible base (including retentive/clasping materials, rests, and teeth), per quadrant | Not a covered benefit.                                               | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care                                                   | Arch identification     |
| D5286    | Prosthodontics (removable) | Removable unilateral partial denture – one piece resin (including retentive/clasping materials, rests, and teeth), per quadrant         | Not a covered benefit.                                               | One per arch per 84 months.<br><br>Note: Includes routine post-delivery care                                                   | Arch identification     |
| D5410    | Prosthodontics (removable) | Adjust complete denture – maxillary                                                                                                     | Not a covered benefit.                                               | Considered part of routine post-delivery care for complete and partial denture for the first 90 days. Once per arch 12 months. | Arch identification     |
| D5411    | Prosthodontics (removable) | Adjust complete denture – mandibular                                                                                                    | Not a covered benefit.                                               | Considered part of routine post-delivery care for complete and partial denture for the first 90 days. Once per arch 12 months. | Arch identification     |
| D5421    | Prosthodontics (removable) | Adjust partial denture – maxillary                                                                                                      | Not a covered benefit.                                               | Considered part of routine post-delivery care for complete and partial denture for the first 90 days. Once per arch 12 months. | Arch identification     |
| D5422    | Prosthodontics (removable) | Adjust partial denture – mandibular                                                                                                     | Not a covered benefit.                                               | Considered part of routine post-delivery care for complete and partial denture for the first 90 days. Once per arch 12 months. | Arch identification     |
| D5511    | Prosthodontics (removable) | Repair broken complete denture base, mandibular                                                                                         | Not covered if initial placement was done within the prior 6 months. | Once per arch 12 months.                                                                                                       | Arch identification     |
| D5512    | Prosthodontics (removable) | Repair broken complete denture base, maxillary                                                                                          | Not covered if initial placement was done within the prior 6 months. | Once per arch 12 months.                                                                                                       | Arch identification     |
| D5520    | Prosthodontics (removable) | Replace missing or broken teeth - complete denture - per tooth                                                                          | Not covered if initial placement was done within the prior 6 months. | Once per tooth per 12 months.                                                                                                  | Tooth identification    |
| D5611    | Prosthodontics (removable) | Repair resin partial denture base, mandibular                                                                                           | Not covered if initial placement was done within the prior 6 months. | Once per arch 12 months.                                                                                                       | Arch identification     |

| CDT Code | ADA Category               | Description of Service                                             | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                    | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                  | Submission Requirements |
|----------|----------------------------|--------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| D5612    | Prosthodontics (removable) | Repair resin partial denture base, maxillary                       | Not covered if initial placement was done within the prior 6 months.                                                                                                                                                                                                                                            | Once per arch 12 months.                                                                                                                                                                                                                                                                                        | Arch identification     |
| D5621    | Prosthodontics (removable) | Repair cast partial framework, mandibular                          | Not covered if initial placement was done within the prior 6 months.                                                                                                                                                                                                                                            | Once per arch 12 months.                                                                                                                                                                                                                                                                                        | Arch identification     |
| D5622    | Prosthodontics (removable) | Repair cast partial framework, maxillary                           | Not covered if initial placement was done within the prior 6 months.                                                                                                                                                                                                                                            | Once per arch 12 months.                                                                                                                                                                                                                                                                                        | Arch identification     |
| D5630    | Prosthodontics (removable) | Repair or replace broken retentive clasping materials, per tooth   | Not covered if initial placement was done within the prior 6 months.                                                                                                                                                                                                                                            | Once per tooth per 12 months.                                                                                                                                                                                                                                                                                   | Tooth identification    |
| D5640    | Prosthodontics (removable) | Replace missing or broken teeth - partial denture - per tooth      | Not covered if initial placement was done within the prior 6 months.                                                                                                                                                                                                                                            | Once per tooth per 12 months.                                                                                                                                                                                                                                                                                   | Tooth identification    |
| D5650    | Prosthodontics (removable) | Add tooth to existing partial denture – per tooth                  | Not covered if initial placement was done within the prior 6 months.                                                                                                                                                                                                                                            | Once per tooth per 12 months.                                                                                                                                                                                                                                                                                   | Tooth identification    |
| D5660    | Prosthodontics (removable) | Add clasp to existing partial denture                              | Not covered if initial placement was done within the prior 6 months.                                                                                                                                                                                                                                            | Once per tooth per 12 months.                                                                                                                                                                                                                                                                                   | Tooth identification    |
| D5670    | Prosthodontics (removable) | Replace all teeth and acrylic on cast metal framework (maxillary)  | Not a covered benefit.                                                                                                                                                                                                                                                                                          | Once per arch per lifetime.                                                                                                                                                                                                                                                                                     | Arch identification     |
| D5671    | Prosthodontics (removable) | Replace all teeth and acrylic on cast metal framework (mandibular) | Not a covered benefit.                                                                                                                                                                                                                                                                                          | Once per arch per lifetime.                                                                                                                                                                                                                                                                                     | Arch identification     |
| D5710    | Prosthodontics (removable) | Rebase complete maxillary denture                                  | One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.<br><br>Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material. | One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.<br><br>Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material. | Arch identification     |
| D5711    | Prosthodontics (removable) | Rebase complete mandibular denture                                 | One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.                                                                                                                               | One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6                                                                                                                                                                     | Arch identification     |

| CDT Code | ADA Category               | Description of Service                     | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                    | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                  | Submission Requirements |
|----------|----------------------------|--------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
|          |                            |                                            | Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.                                                                                                                                                                                          | months of dispensing date of denture.<br><br>Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.                                                                                                                                             |                         |
| D5720    | Prosthodontics (removable) | Rebase maxillary partial denture           | One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.<br><br>Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material. | One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.<br><br>Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material. | Arch identification     |
| D5721    | Prosthodontics (removable) | Rebase mandibular partial denture          | One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.<br><br>Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material. | One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.<br><br>Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material. | Arch identification     |
| D5725    | Prosthodontics (removable) | Rebase hybrid prosthesis                   | Once per arch per 24 months.<br><br>Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.                                                                                                                                                      | Once per arch per 36 months.<br><br>Note: Dental rebase procedures are considered to be the process of refitting a denture by replacing the base material.                                                                                                                                                      | Arch identification     |
| D5730    | Prosthodontics (removable) | Reline complete maxillary denture – direct | One per arch per 24 months; adjustments are considered part of routine post-delivery care for                                                                                                                                                                                                                   | One per arch per 24 months; adjustments are considered part of routine post-delivery                                                                                                                                                                                                                            | Arch identification     |

| CDT Code | ADA Category               | Description of Service                      | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                         | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                       | Submission Requirements |
|----------|----------------------------|---------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
|          |                            |                                             | <p>complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p>                                                                                               | <p>care for complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p>                                                                                      |                         |
| D5731    | Prosthodontics (removable) | Reline complete mandibular denture – direct | <p>One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p> | <p>One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p> | Arch identification     |
| D5740    | Prosthodontics (removable) | Reline maxillary partial denture –direct    | <p>One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p> | <p>One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p> | Arch identification     |
| D5741    | Prosthodontics (removable) | Reline mandibular partial denture – direct  | <p>One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p>                                                                                                                                             | <p>One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p>                                                                                                                                             | Arch identification     |

| CDT Code | ADA Category               | Description of Service                        | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                         | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                       | Submission Requirements |
|----------|----------------------------|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
|          |                            |                                               | Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.                                                                                                                                                                                                 | Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.                                                                                                                                                                                                 |                         |
| D5750    | Prosthodontics (removable) | Reline complete maxillary denture – indirect  | <p>One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p> | <p>One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p> | Arch identification     |
| D5751    | Prosthodontics (removable) | Reline complete mandibular denture – indirect | <p>One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p> | <p>One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p> | Arch identification     |
| D5760    | Prosthodontics (removable) | Reline maxillary partial denture – indirect   | <p>One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p> | <p>One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.</p> <p>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material.</p> | Arch identification     |

| CDT Code | ADA Category               | Description of Service                                                                         | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                                                                                  | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                | Submission Requirements |
|----------|----------------------------|------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| D5761    | Prosthodontics (removable) | Reline mandibular partial denture – indirect                                                   | One per arch per 24 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.<br><br>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material. | One per arch per 36 months; adjustments are considered part of routine post-delivery care for complete and partial denture rebases within 6 months of dispensing date of denture.<br><br>Note: Denture reline procedures are considered to be the process of resurfacing the tissue side of a denture with new base material. | Arch identification     |
| D5765    | Prosthodontics (removable) | Soft liner for complete or partial removable denture – indirect                                | Once per arch per 24 months.                                                                                                                                                                                                                                                                                                  | Once per arch per 36 months.                                                                                                                                                                                                                                                                                                  | Arch identification     |
| D5810    | Prosthodontics (removable) | Interim complete denture (maxillary)                                                           | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | None                    |
| D5811    | Prosthodontics (removable) | Interim complete denture (mandibular)                                                          | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | None                    |
| D5820    | Prosthodontics (removable) | Interim partial denture (including retentive/clasping materials, rests, and teeth), maxillary  | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | One per arch per lifetime.                                                                                                                                                                                                                                                                                                    | Arch identification     |
| D5821    | Prosthodontics (removable) | Interim partial denture (including retentive/clasping materials, rests, and teeth), mandibular | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | One per arch per lifetime.                                                                                                                                                                                                                                                                                                    | Arch identification     |
| D5850    | Prosthodontics (removable) | Tissue conditioning, maxillary                                                                 | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | One per arch per 36 months.                                                                                                                                                                                                                                                                                                   | Arch identification     |
| D5851    | Prosthodontics (removable) | Tissue conditioning, mandibular                                                                | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | One per arch per 36 months.                                                                                                                                                                                                                                                                                                   | Arch identification     |
| D5862    | Prosthodontics (removable) | Precision attachment, by report                                                                | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | None                    |
| D5863    | Prosthodontics (removable) | Overdenture – complete maxillary                                                               | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | One per arch per 84 months.                                                                                                                                                                                                                                                                                                   | Arch identification     |
| D5864    | Prosthodontics (removable) | Overdenture – partial maxillary                                                                | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | One per arch per 84 months.                                                                                                                                                                                                                                                                                                   | Arch identification     |
| D5865    | Prosthodontics (removable) | Overdenture – complete mandibular                                                              | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | One per arch per 84 months.                                                                                                                                                                                                                                                                                                   | Arch identification     |
| D5866    | Prosthodontics (removable) | Overdenture – partial mandibular                                                               | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | One per arch per 84 months.                                                                                                                                                                                                                                                                                                   | Arch identification     |
| D5867    | Prosthodontics (removable) | Replacement of replaceable part of semi-precision or precision attachment, per attachment      | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | None                    |
| D5875    | Prosthodontics (removable) | Modification of removable prosthesis following implant surgery                                 | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | Not a covered benefit.                                                                                                                                                                                                                                                                                                        | None                    |

| CDT Code | ADA Category               | Description of Service                                    | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements |
|----------|----------------------------|-----------------------------------------------------------|----------------------------------------------|------------------------------------------------|-------------------------|
| D5876    | Prosthodontics (removable) | Add metal substructure to acrylic full denture (per arch) | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5899    | Prosthodontics (removable) | Unspecified removable prosthodontic procedure, by report  | Individual consideration.                    | Individual consideration.                      | Detailed narrative      |
| D5911    | Maxillofacial prosthetics  | Facial moulage (sectional)                                | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5912    | Maxillofacial prosthetics  | Facial moulage (complete)                                 | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5913    | Maxillofacial prosthetics  | Nasal prosthesis                                          | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5914    | Maxillofacial prosthetics  | Auricula prosthesis                                       | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5915    | Maxillofacial prosthetics  | Orbital prosthesis                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5916    | Maxillofacial prosthetics  | Ocular prosthesis                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5919    | Maxillofacial prosthetics  | Facial prosthesis                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5922    | Maxillofacial prosthetics  | Nasal septal prosthesis                                   | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5923    | Maxillofacial prosthetics  | Ocular prosthesis, interim                                | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5924    | Maxillofacial prosthetics  | Cranial prosthesis                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5925    | Maxillofacial prosthetics  | Facial augmentation implant prosthesis                    | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5926    | Maxillofacial prosthetics  | Nasal prosthesis, replacement                             | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5927    | Maxillofacial prosthetics  | Auricular prosthesis, replacement                         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5928    | Maxillofacial prosthetics  | Orbital prosthesis, replacement                           | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5929    | Maxillofacial prosthetics  | Facial prosthesis, replacement                            | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5931    | Maxillofacial prosthetics  | Obturator prosthesis, surgical                            | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5932    | Maxillofacial prosthetics  | Obturator prosthesis, definitive                          | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5933    | Maxillofacial prosthetics  | Obturator prosthesis, modification                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5934    | Maxillofacial prosthetics  | Mandibular resection prosthesis with guide flange         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |

| <b>CDT Code</b> | <b>ADA Category</b>       | <b>Description of Service</b>                                    | <b>Pediatric EHB Procedure Guidelines Ages 0-19</b> | <b>Adult EHB Procedure Guidelines Ages 19 &amp; older</b> | <b>Submission Requirements</b> |
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| D5935           | Maxillofacial prosthetics | Mandibular resection prosthesis without guide flange             | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5936           | Maxillofacial prosthetics | Obturator prosthesis, interim                                    | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5937           | Maxillofacial prosthetics | Trismus appliance (not for TMD treatment)                        | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5951           | Maxillofacial prosthetics | Feeding aid                                                      | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5952           | Maxillofacial prosthetics | Speech aid prosthesis, pediatric                                 | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5953           | Maxillofacial prosthetics | Speech aid prosthesis, adult                                     | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5954           | Maxillofacial prosthetics | Palatal augmentation prosthesis                                  | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5955           | Maxillofacial prosthetics | Palatal lift prosthesis, definitive                              | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5958           | Maxillofacial prosthetics | Palatal lift prosthesis, interim                                 | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5959           | Maxillofacial prosthetics | Palatal lift prosthesis, modification                            | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5960           | Maxillofacial prosthetics | Speech aid prosthesis, modification                              | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5982           | Maxillofacial prosthetics | Surgical stent                                                   | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5983           | Maxillofacial prosthetics | Radiation carrier                                                | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5984           | Maxillofacial prosthetics | Radiation shield                                                 | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5985           | Maxillofacial prosthetics | Radiation cone locator                                           | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5986           | Maxillofacial prosthetics | Fluoride gel carrier                                             | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5987           | Maxillofacial prosthetics | Commissure splint                                                | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5988           | Maxillofacial prosthetics | Surgical splint                                                  | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5991           | Maxillofacial prosthetics | Vesiculobullous disease medicament carrier                       | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5992           | Maxillofacial prosthetics | Adjust maxillofacial prosthetic appliance, by report             | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |
| D5993           | Maxillofacial prosthetics | Maintenance and cleaning of a maxillofacial prosthesis (extra or | Not a covered benefit.                              | Not a covered benefit.                                    | None                           |

| CDT Code | ADA Category              | Description of Service                                                                                                                                                                           | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements |
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|          |                           | intraoral) other than required adjustments, by report                                                                                                                                            |                                              |                                                |                         |
| D5995    | Maxillofacial prosthetics | Periodontal medicament carrier with peripheral seal – laboratory processed – maxillary                                                                                                           | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5996    | Maxillofacial prosthetics | Periodontal medicament carrier with peripheral seal – laboratory processed - mandibular                                                                                                          | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D5999    | Maxillofacial prosthetics | Unspecified maxillofacial prosthesis, by report                                                                                                                                                  | Individual consideration.                    | Individual consideration.                      | Detailed narrative      |
| D6010    | Implant                   | Surgical placement of implant body, endosteal implant                                                                                                                                            | Not a covered benefit                        | Not a covered benefit                          | None                    |
| D6011    | Implant                   | Surgical access to an implant body (Second stage implant surgery)                                                                                                                                | Not a covered benefit                        | Not a covered benefit                          | None                    |
| D6012    | Implant                   | Surgical placement of interim implant body for transitional prosthesis: endosteal implant                                                                                                        | Not a covered benefit                        | Not a covered benefit                          | None                    |
| D6013    | Implant                   | Surgical placement of mini implant                                                                                                                                                               | Not a covered benefit                        | Not a covered benefit                          | None                    |
| D6040    | Implant                   | Surgical placement: eposteal implant                                                                                                                                                             | Not a covered benefit                        | Not a covered benefit                          | None                    |
| D6050    | Implant                   | Surgical placement: transosteal implant                                                                                                                                                          | Not a covered benefit                        | Not a covered benefit                          | None                    |
| D6051    | Implant                   | Placement of interim implant abutment                                                                                                                                                            | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6055    | Implant                   | Connecting bar – implant- supported or abutment-supported                                                                                                                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6056    | Implant                   | Prefabricated abutment – includes modification and placement                                                                                                                                     | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6057    | Implant                   | Custom fabricated abutment – includes placement                                                                                                                                                  | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6058    | Implant                   | Abutment-supported porcelain/ ceramic crown. A single crown restoration that is retained, supported, and stabilized by an abutment on an implant                                                 | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6059    | Implant                   | Abutment-supported porcelain fused to metal crown (high noble metal) A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant           | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6060    | Implant                   | Abutment supported porcelain fused to metal crown (predominantly base metal). A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant. | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6061    | Implant                   | Abutment-supported porcelain fused to metal crown (noble metal). A single metal-ceramic crown restoration that is                                                                                | Not a covered benefit.                       | Not a covered benefit.                         | None                    |

| CDT Code | ADA Category | Description of Service                                                                                                                                                                                                    | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements |
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|          |              | retained, supported, and stabilized by an abutment on an implant.                                                                                                                                                         |                                              |                                                |                         |
| D6062    | Implant      | Abutment-supported cast metal crown (high noble metal). A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant.                                                | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6063    | Implant      | Abutment-supported cast metal crown (predominantly base metal). A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant.                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6064    | Implant      | Abutment-supported cast metal crown (noble metal). A single metal-ceramic crown restoration that is retained, supported, and stabilized by an abutment on an implant.                                                     | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6065    | Implant      | Implant-supported porcelain/ceramic crown                                                                                                                                                                                 | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6066    | Implant      | Implant supported crown – porcelain fused to high noble alloys                                                                                                                                                            | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6067    | Implant      | Implant-supported crown – high noble alloys                                                                                                                                                                               | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6068    | Implant      | Abutment supported retainer for porcelain/ceramic FPD. A ceramic retainer for a fixed partial denture that gains retention, support, and stability from an abutment on an implant.                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6069    | Implant      | Abutment-supported retainer for porcelain fused to metal FPD (high noble metal). A metal- ceramic retainer for a fixed partial denture that gains retention, support, and stability from an abutment on an implant.       | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6070    | Implant      | Abutment-supported retainer for porcelain fused to metal FPD (predominately base metal) A metal-ceramic retainer for a fixed partial denture that gains retention, support, and stability from an abutment on an implant. | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6071    | Implant      | Abutment-supported retainer for porcelain fused to metal FPD (noble metal)                                                                                                                                                | Not a covered benefit.                       | Not a covered benefit.                         | None                    |

| CDT Code | ADA Category | Description of Service                                                                                                                                                                                                         | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements |
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| D6072    | Implant      | Abutment-supported retainer for cast metal FPD (high noble metal)                                                                                                                                                              | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6073    | Implant      | Abutment-supported retainer for cast metal FPD (predominately base metal)                                                                                                                                                      | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6074    | Implant      | Abutment-supported retainer for cast metal FPD (noble metal)                                                                                                                                                                   | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6075    | Implant      | Implant-supported retainer for ceramic FPD                                                                                                                                                                                     | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6076    | Implant      | Implant-supported retainer for FPD – porcelain fused to high noble alloys)                                                                                                                                                     | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6077    | Implant      | Implant-supported retainer for cast metal FPD – high noble alloys)                                                                                                                                                             | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6080    | Implant      | Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments                                                                             | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6081    | Implant      | Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6082    | Implant      | Implant-supported crown – porcelain fused to predominately base alloys                                                                                                                                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6083    | Implant      | Implant-supported crown –porcelain fused to noble alloys                                                                                                                                                                       | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6084    | Implant      | Implant-supported crown – porcelain fused to titanium and titanium alloys                                                                                                                                                      | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6085    | Implant      | Provisional implant crown                                                                                                                                                                                                      | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6086    | Implant      | Implant supported crown – predominantly base alloys                                                                                                                                                                            | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6087    | Implant      | Implant supported crown – noble alloys                                                                                                                                                                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6088    | Implant      | Implant-supported crown – titanium and titanium alloys                                                                                                                                                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6089    | Implant      | Accessing and retorquing loose implant screw – per screw                                                                                                                                                                       | Covered by rider only.                       | Covered by rider only.                         | Tooth identification    |
| D6090    | Implant      | Repair of implant/abutment supported prosthesis                                                                                                                                                                                | Not a covered benefit.                       | Covered by rider only.                         | Arch identification     |
| D6091    | Implant      | Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment                                                                                             | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6092    | Implant      | Recement or re-bond implant/abutment-supported crown                                                                                                                                                                           | Not a covered benefit.                       | Not a covered benefit.                         | None                    |

| CDT Code | ADA Category | Description of Service                                                                                                            | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements |
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| D6093    | Implant      | Recement or re-bond implant/abutment-supported fixed partial denture                                                              | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6094    | Implant      | Abutment-supported crown – titanium and titanium alloys                                                                           | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6096    | Implant      | Remove broken implant retaining screw                                                                                             | Covered by rider only.                       | Covered by rider only.                         | Tooth identification    |
| D6097    | Implant      | Abutment-supported crown – porcelain fused to titanium and titanium alloys                                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6098    | Implant      | Implant supported retainer – porcelain fused to predominantly base alloys                                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6099    | Implant      | Implant supported retainer for FPD – porcelain fused to noble alloys                                                              | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6100    | Implant      | Surgical removal of implant body                                                                                                  | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6101    | Implant      | Debridement of a peri-implant defect and surface cleaning of exposed implant surfaces, including flap entry and closure           | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6102    | Implant      | Debridement and osseous contouring of a peri-implant defect; includes surface cleaning of exposed implant surfaces and flap entry | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6103    | Implant      | Bone graft for repair of peri-implant defect – not including flap entry and closure                                               | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6104    | Implant      | Bone graft at time of implant placement                                                                                           | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6105    | Implant      | Removal of implant body not requiring bone removal or flap elevation                                                              | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6106    | Implant      | Guided tissue regeneration – resorbable barrier, per implant                                                                      | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6107    | Implant      | Guided tissue regeneration – non-resorbable barrier, per implant                                                                  | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6110    | Implant      | Implant /abutment supported removable denture for edentulous arch – maxillary                                                     | Once per 60 months.                          | Once per 60 months.                            | Arch identification     |
| D6111    | Implant      | Implant /abutment supported removable denture for edentulous arch – mandibular                                                    | Once per 60 months.                          | Once per 60 months.                            | Arch identification     |
| D6112    | Implant      | Implant /abutment supported removable denture for partially edentulous arch – maxillary                                           | Once per 60 months.                          | Once per 60 months.                            | Arch identification     |
| D6113    | Implant      | Implant /abutment supported removable denture for partially edentulous arch – mandibular                                          | Once per 60 months.                          | Once per 60 months.                            | Arch identification     |
| D6114    | Implant      | Implant /abutment supported fixed denture for edentulous arch – maxillary                                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D6115    | Implant      | Implant /abutment supported fixed denture for edentulous arch – mandibular                                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |

| CDT Code | ADA Category           | Description of Service                                                                                                                  | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                                                                                          | Submission Requirements |
|----------|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
| D6116    | Implant                | Implant /abutment supported fixed denture for partially edentulous arch – maxillary                                                     | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6117    | Implant                | Implant /abutment supported fixed denture for partially edentulous arch – mandibular                                                    | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6118    | Implant                | Implant/abutment supported interim fixed denture for edentulous arch – mandibular                                                       | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6119    | Implant                | Implant/abutment supported interim fixed denture for edentulous arch – maxillary                                                        | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6120    | Implant                | Implant supported retainer – porcelain fused to titanium and titanium alloys                                                            | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6121    | Implant                | Implant-supported retainer for metal FPD – predominantly base alloys                                                                    | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6122    | Implant                | Implant-supported retainer for metal FPD – noble alloys                                                                                 | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6123    | Implant                | Implant-supported retainer for metal FPD – titanium and titanium alloys                                                                 | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6180    | Implant                | Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6190    | Implant                | Radiographic/surgical implant index, by report                                                                                          | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6191    | Implant                | Semi-precision abutment – placement                                                                                                     | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6192    | Implant                | Semi-precision attachment – placement                                                                                                   | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6193    | Implant                | Replacement of an implant screw                                                                                                         | Covered by rider only.                       | Covered by rider only.                                                                                                                  | Tooth identification    |
| D6194    | Implant                | Abutment supported retainer crown for FPD – titanium and titanium alloys                                                                | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6195    | Implant                | Abutment supported retainer – porcelain fused to titanium and titanium alloys                                                           | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6197    | Implant                | Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant       | Not a covered benefit.                       | One per tooth per 12 months. Considered part of routine post-delivery care for abutment/implant supported crowns for the first 90 days. | Tooth identification    |
| D6198    | Implant                | Remove interim implant component                                                                                                        | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6199    | Implant                | Unspecified implant procedure, by report                                                                                                | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6205    | Prosthodontics (fixed) | Pontic – indirect resin-based composite                                                                                                 | Not a covered benefit.                       | Not a covered benefit.                                                                                                                  | None                    |
| D6210    | Prosthodontics (fixed) | Pontic – cast high noble                                                                                                                | Not a covered benefit.                       | One pontic per permanent tooth per 84 months.                                                                                           | Tooth identification    |

| CDT Code | ADA Category           | Description of Service                                                                            | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older     | Submission Requirements                        |
|----------|------------------------|---------------------------------------------------------------------------------------------------|----------------------------------------------|----------------------------------------------------|------------------------------------------------|
| D6211    | Prosthodontics (fixed) | Pontic – cast predominantly base metal                                                            | Not a covered benefit.                       | One pontic per permanent tooth per 84 months.      | Tooth identification                           |
| D6212    | Prosthodontics (fixed) | Pontic – cast noble metal                                                                         | Not a covered benefit.                       | One pontic per permanent tooth per 84 months.      | Tooth identification                           |
| D6214    | Prosthodontics (fixed) | Pontic – titanium and titanium alloys                                                             | Not a covered benefit.                       | One pontic per permanent tooth per 84 months.      | Tooth identification                           |
| D6240    | Prosthodontics (fixed) | Pontic – porcelain fused to high noble metal                                                      | Not a covered benefit.                       | One pontic per permanent tooth per 84 months.      | Tooth identification                           |
| D6241    | Prosthodontics (fixed) | Pontic – porcelain fused to predominantly base metal                                              | Once per 60 months per tooth.                | One pontic per permanent tooth per 84 months.      | Tooth identification                           |
| D6242    | Prosthodontics (fixed) | Pontic – porcelain fused to noble metal                                                           | Not a covered benefit.                       | One pontic per permanent tooth per 84 months.      | Tooth identification                           |
| D6243    | Prosthodontics (fixed) | Pontic – porcelain fused to titanium and titanium alloys                                          | Not a covered benefit.                       | One pontic per permanent tooth per 84 months.      | Tooth identification                           |
| D6245    | Prosthodontics (fixed) | Pontic – porcelain/ceramic                                                                        | Not a covered benefit.                       | One pontic per permanent tooth per 84 months.      | Tooth identification                           |
| D6250    | Prosthodontics (fixed) | Pontic – resin with high noble metal                                                              | Not a covered benefit.                       | One pontic per permanent tooth per 84 months.      | Tooth identification                           |
| D6251    | Prosthodontics (fixed) | Pontic – resin with predominantly base metal                                                      | Not a covered benefit.                       | One pontic per permanent tooth per 84 months.      | Tooth identification                           |
| D6252    | Prosthodontics (fixed) | Pontic – resin with noble metal                                                                   | Not a covered benefit.                       | One pontic per permanent tooth per 84 months.      | Tooth identification                           |
| D6253    | Prosthodontics (fixed) | Interim pontic – further treatment or completion of diagnosis necessary prior to final impression | Not a covered benefit.                       | Not a covered benefit.                             | None                                           |
| D6545    | Prosthodontics (fixed) | Retainer – cast metal for resin-bonded fixed prosthesis                                           | Not a covered benefit.                       | One restoration per permanent tooth per 84 months. | Tooth identification                           |
| D6548    | Prosthodontics (fixed) | Retainer – porcelain/ ceramic for resin-bonded fixed prosthesis                                   | Not a covered benefit.                       | One restoration per permanent tooth per 84 months. | Tooth identification                           |
| D6549    | Prosthodontics (fixed) | Resin retainer – for resin bonded fixed prosthesis                                                | Not a covered benefit.                       | One restoration per permanent tooth per 84 months. | Tooth identification                           |
| D6600    | Prosthodontics (fixed) | Retainer inlay – porcelain/ceramic, two surfaces                                                  | Not a covered benefit.                       | One restoration per tooth surface per 84 months.   | Tooth identification<br>Surface identification |
| D6601    | Prosthodontics (fixed) | Retainer inlay – porcelain/ceramic, three or more surfaces                                        | Not a covered benefit.                       | One restoration per tooth surface per 84 months.   | Tooth identification<br>Surface identification |
| D6602    | Prosthodontics (fixed) | Retainer inlay – cast high noble metal, two surfaces                                              | Not a covered benefit.                       | One restoration per tooth surface per 84 months.   | Tooth identification                           |

| CDT Code | ADA Category           | Description of Service                                                 | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older   | Submission Requirements                                                          |
|----------|------------------------|------------------------------------------------------------------------|----------------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------|
|          |                        |                                                                        |                                              |                                                  | Surface identification                                                           |
| D6603    | Prosthodontics (fixed) | Retainer inlay – cast high noble metal, three or more surfaces         | Not a covered benefit.                       | One restoration per tooth surface per 84 months. | Tooth identification<br>Surface identification                                   |
| D6604    | Prosthodontics (fixed) | Retainer inlay – cast predominantly base metal, two surfaces           | Not a covered benefit.                       | One restoration per tooth surface per 84 months. | Tooth identification<br>Surface identification                                   |
| D6605    | Prosthodontics (fixed) | Retainer inlay – cast predominantly base metal, three or more surfaces | Not a covered benefit.                       | One restoration per tooth surface per 84 months. | Tooth identification<br>Surface identification                                   |
| D6606    | Prosthodontics (fixed) | Retainer inlay – cast noble metal, two surfaces                        | Not a covered benefit.                       | One restoration per tooth surface per 84 months. | Tooth identification<br>Surface identification                                   |
| D6607    | Prosthodontics (fixed) | Retainer inlay – cast noble metal, three or more surfaces              | Not a covered benefit.                       | One restoration per tooth surface per 84 months. | Tooth identification<br>Surface identification                                   |
| D6608    | Prosthodontics (fixed) | Retainer onlay –porcelain/ceramic, two surfaces                        | Not a covered benefit.                       | Once per tooth per 84 months.                    | Tooth identification<br><br>Surface identification – must include B or L surface |
| D6609    | Prosthodontics (fixed) | Retainer onlay – porcelain/ ceramic, three or more surfaces            | Not a covered benefit.                       | Once per tooth per 84 months.                    | Tooth identification<br><br>Surface identification – must include B or L surface |
| D6610    | Prosthodontics (fixed) | Retainer onlay – cast high noble metal, two surfaces                   | Not a covered benefit.                       | Once per tooth per 84 months.                    | Tooth identification<br><br>Surface identification – must include B or L surface |

| <b>CDT Code</b> | <b>ADA Category</b>    | <b>Description of Service</b>                                          | <b>Pediatric EHB Procedure Guidelines Ages 0-19</b> | <b>Adult EHB Procedure Guidelines Ages 19 &amp; older</b> | <b>Submission Requirements</b>                                                   |
|-----------------|------------------------|------------------------------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|----------------------------------------------------------------------------------|
| D6611           | Prosthodontics (fixed) | Retainer onlay – cast high noble metal, three or more surfaces         | Not a covered benefit.                              | Once per tooth per 84 months.                             | Tooth identification<br><br>Surface identification – must include B or L surface |
| D6612           | Prosthodontics (fixed) | Retainer onlay – cast predominantly base metal, two surfaces           | Not a covered benefit.                              | Once per tooth per 84 months.                             | Tooth identification<br><br>Surface identification – must include B or L surface |
| D6613           | Prosthodontics (fixed) | Retainer onlay – cast predominantly base metal, three or more surfaces | Not a covered benefit.                              | Once per tooth per 84 months.                             | Tooth identification<br><br>Surface identification – must include B or L surface |
| D6614           | Prosthodontics (fixed) | Retainer onlay – cast noble metal, two surfaces                        | Not a covered benefit.                              | Once per tooth per 84 months.                             | Tooth identification<br><br>Surface identification – must include B or L surface |
| D6615           | Prosthodontics (fixed) | Retainer onlay – cast noble metal, three or more surfaces              | Not a covered benefit.                              | Once per tooth per 84 months.                             | Tooth identification<br><br>Surface identification – must include B or L surface |
| D6624           | Prosthodontics (fixed) | Retainer inlay – titanium                                              | Not a covered benefit.                              | Not a covered benefit.                                    | None                                                                             |
| D6634           | Prosthodontics (fixed) | Retainer onlay – titanium                                              | Not a covered benefit.                              | Once per tooth per 84 months.                             | Tooth identification<br><br>Surface identification – must include B or L surface |

| CDT Code | ADA Category           | Description of Service                                           | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older                            | Submission Requirements |
|----------|------------------------|------------------------------------------------------------------|----------------------------------------------|---------------------------------------------------------------------------|-------------------------|
| D6710    | Prosthodontics (fixed) | Retainer crown – indirect resin-based composite                  | Not a covered benefit.                       | Not a covered benefit.                                                    | None                    |
| D6720    | Prosthodontics (fixed) | Retainer crown – resin with high noble metal                     | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6721    | Prosthodontics (fixed) | Retainer crown – resin with predominantly base metal             | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6722    | Prosthodontics (fixed) | Retainer crown – resin with noble metal                          | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6740    | Prosthodontics (fixed) | Retainer crown – porcelain/ceramic                               | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6750    | Prosthodontics (fixed) | Retainer crown – porcelain fused to high noble                   | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6751    | Prosthodontics (fixed) | Retainer crown – porcelain fused to predominantly base metal     | Once per 60 months per tooth.                | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6752    | Prosthodontics (fixed) | Retainer crown – porcelain fused to noble metal                  | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6753    | Prosthodontics (fixed) | Retainer crown – porcelain fused to titanium and titanium alloys | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6780    | Prosthodontics (fixed) | Retainer crown – $\frac{3}{4}$ cast high noble metal             | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6781    | Prosthodontics (fixed) | Retainer crown – $\frac{3}{4}$ cast predominately base metal     | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6782    | Prosthodontics (fixed) | Retainer crown – $\frac{3}{4}$ cast noble metal                  | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6783    | Prosthodontics (fixed) | Retainer crown – $\frac{3}{4}$ porcelain/ceramic                 | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6784    | Prosthodontics (fixed) | Retainer crown $\frac{3}{4}$ – titanium and titanium alloys      | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |
| D6790    | Prosthodontics (fixed) | Retainer crown – full cast high noble metal                      | Not a covered benefit.                       | One retainer crown or cast restoration per permanent tooth per 84 months. | Tooth identification    |

| CDT Code | ADA Category                 | Description of Service                                                                                    | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                      | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                    | Submission Requirements                           |
|----------|------------------------------|-----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------|
| D6791    | Prosthodontics (fixed)       | Retainer crown – full cast predominantly base metal                                                       | Not a covered benefit.                                                                                                                                                                                                                                            | One crown or cast restoration per permanent tooth per 84 months.                                                                                                                                                                                                  | Tooth identification                              |
| D6792    | Prosthodontics (fixed)       | Retainer crown – full cast noble metal                                                                    | Not a covered benefit.                                                                                                                                                                                                                                            | One crown or cast restoration per permanent tooth per 84 months.                                                                                                                                                                                                  | Tooth identification                              |
| D6793    | Prosthodontics (fixed)       | Interim retainer crown – further treatment or completion of diagnosis necessary prior to final impression | Not a covered benefit.                                                                                                                                                                                                                                            | Not a covered benefit.                                                                                                                                                                                                                                            | Tooth identification                              |
| D6794    | Prosthodontics (fixed)       | Retainer crown – titanium and titanium alloys                                                             | Not a covered benefit.                                                                                                                                                                                                                                            | One crown or cast restoration per permanent tooth per 84 months.                                                                                                                                                                                                  | Tooth identification                              |
| D6920    | Prosthodontics (fixed)       | Connector bar                                                                                             | Not a covered benefit.                                                                                                                                                                                                                                            | Not a covered benefit.                                                                                                                                                                                                                                            | None                                              |
| D6930    | Prosthodontics (fixed)       | Recement or re-bond fixed partial denture                                                                 | Not payable within 6 months of the placement of the fixed partial denture.                                                                                                                                                                                        | One re-cementation per 12 months.                                                                                                                                                                                                                                 | Tooth identification                              |
| D6940    | Prosthodontics (fixed)       | Stress breaker                                                                                            | Not a covered benefit.                                                                                                                                                                                                                                            | Not a covered benefit.                                                                                                                                                                                                                                            | None                                              |
| D6950    | Prosthodontics (fixed)       | Precision attachment                                                                                      | Not a covered benefit.                                                                                                                                                                                                                                            | Not a covered benefit.                                                                                                                                                                                                                                            | None                                              |
| D6980    | Prosthodontics (fixed)       | Fixed partial denture repair necessitated by restorative material failure                                 | Covered.                                                                                                                                                                                                                                                          | One repair per 12 months.                                                                                                                                                                                                                                         | Quadrant identification<br><br>Detailed narrative |
| D6985    | Prosthodontics (fixed)       | Pediatric partial denture, fixed                                                                          | Not a covered benefit.                                                                                                                                                                                                                                            | Not a covered benefit.                                                                                                                                                                                                                                            | None                                              |
| D6999    | Prosthodontics (fixed)       | Unspecified fixed prosthodontic procedure, by report                                                      | Individual consideration.                                                                                                                                                                                                                                         | Individual consideration.                                                                                                                                                                                                                                         | Detailed narrative                                |
| D7111    | Oral & maxillofacial surgery | Extraction – coronal remnants, deciduous tooth                                                            | One per tooth per lifetime.<br><br>Note: Includes local anesthesia, suturing, if needed, and routine post-operative care. Bone grafts (D4263, D4264, D4265) and GTR membranes (D4266, D4267) are not covered in conjunction with oral surgery codes (D7000-D7999) | One per tooth per lifetime.<br><br>Note: Includes local anesthesia, suturing, if needed, and routine post-operative care. Bone grafts (D4263, D4264, D4265) and GTR membranes (D4266, D4267) are not covered in conjunction with oral surgery codes (D7000-D7999) | Tooth identification                              |
| D7140    | Oral & maxillofacial surgery | Extraction – erupted tooth or exposed root (elevation and/or forcep removal)                              | One per tooth per lifetime.<br><br>Note: Includes local anesthesia, suturing, if needed, and routine post-operative care. Bone grafts (D4263, D4264, D4265) and                                                                                                   | One per tooth per lifetime. If D7140, D7210, or D7250 is performed within 90 days after a D3921, payment for the extraction will be reduced by the payment of D3921.                                                                                              | Tooth identification                              |

| CDT Code | ADA Category                 | Description of Service                                                                                                                                | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                                      | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                                                                                                                                                                                                                                                                   | Submission Requirements |
|----------|------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------|
|          |                              |                                                                                                                                                       | GTR membranes (D4266, D4267) are not covered in conjunction with oral surgery codes (D7000-D7999)                                                                                                                                                                 | Note: Includes local anesthesia, suturing, if needed, and routine post-operative care. Bone grafts (D4263, D4264, D4265) and GTR membranes (D4266, D4267) are not covered in conjunction with oral surgery codes (D7000-D7999)                                                                                                                                                                                   |                         |
| D7210    | Oral & maxillofacial surgery | Surgical removal of an erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated | One per tooth per lifetime.<br><br>Note: Includes local anesthesia, suturing, if needed, and routine post-operative care. Bone grafts (D4263, D4264, D4265) and GTR membranes (D4266, D4267) are not covered in conjunction with oral surgery codes (D7000-D7999) | One per tooth per lifetime.<br><br>If D7140, D7210 or D7250 is performed within 90 days after a D3921, payment for the extraction will be reduced by the payment of D3921.<br><br>Note: Includes local anesthesia, suturing, if needed, and routine post-operative care. Bone grafts (D4263, D4264, D4265) and GTR membranes (D4266, D4267) are not covered in conjunction with oral surgery codes (D7000-D7999) | Tooth identification    |
| D7220    | Oral & maxillofacial surgery | Removal of impacted tooth – soft tissue                                                                                                               | One per tooth per lifetime.                                                                                                                                                                                                                                       | One per tooth per lifetime.                                                                                                                                                                                                                                                                                                                                                                                      | Tooth identification    |
| D7230    | Oral & maxillofacial surgery | Removal of impacted tooth – partially bony                                                                                                            | One per tooth per lifetime.                                                                                                                                                                                                                                       | One per tooth per lifetime.                                                                                                                                                                                                                                                                                                                                                                                      | Tooth identification    |
| D7240    | Oral & maxillofacial surgery | Removal of impacted tooth – completely bony                                                                                                           | One per tooth per lifetime.                                                                                                                                                                                                                                       | One per tooth per lifetime.                                                                                                                                                                                                                                                                                                                                                                                      | Tooth identification    |
| D7241    | Oral & maxillofacial surgery | Removal of impacted tooth – completely bony, with unusual surgical complications                                                                      | Not a covered benefit.                                                                                                                                                                                                                                            | One per tooth per lifetime.                                                                                                                                                                                                                                                                                                                                                                                      | Tooth identification    |
| D7250    | Oral & maxillofacial surgery | Surgical removal of residual tooth roots (cutting procedure)                                                                                          | Only covered for teeth that are symptomatic, carious or pathologic.                                                                                                                                                                                               | One per tooth per lifetime. If D7140, D7210 or D7250 is performed within 90 days after a D3921, payment for the extraction will be reduced by the payment of D3921.                                                                                                                                                                                                                                              | Tooth identification    |
| D7251    | Oral & maxillofacial surgery | Coronectomy – intentional partial tooth removal, impacted teeth only                                                                                  | Not a covered benefit.                                                                                                                                                                                                                                            | Once per tooth per lifetime (D3921 or D7251).                                                                                                                                                                                                                                                                                                                                                                    | Tooth identification    |

| CDT Code | ADA Category                 | Description of Service                                                                                      | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                         | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                       | Submission Requirements                                                              |
|----------|------------------------------|-------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|
| D7252    | Oral & maxillofacial surgery | Partial extraction for immediate implant placement                                                          | Once per permanent canine or incisor tooth per lifetime for members age 16+ when done in conjunction with implant placement on same date of service. | Once per permanent canine or incisor tooth per lifetime for members age 16+ when done in conjunction with implant placement on same date of service. | Tooth identification                                                                 |
| D7259    | Oral & maxillofacial surgery | Nerve dissection                                                                                            | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                                                                                 |
| D7260    | Oral & maxillofacial surgery | Oroantral fistula closure                                                                                   | Not a covered benefit.                                                                                                                               | Individual consideration.                                                                                                                            | Periapical or panoramic radiograph<br><br>Operative note<br><br>Tooth identification |
| D7261    | Oral & maxillofacial surgery | Primary closure of a sinus perforation                                                                      | Not a covered benefit.                                                                                                                               | Individual consideration.                                                                                                                            | Periapical or panoramic radiograph<br><br>Operative note<br><br>Tooth identification |
| D7270    | Oral & maxillofacial surgery | Tooth reimplantation and/or stabilization of accidentally avulsed or displaced tooth                        | Covered for permanent teeth.                                                                                                                         | Once per permanent tooth per lifetime.                                                                                                               | Tooth identification                                                                 |
| D7272    | Oral & maxillofacial surgery | Tooth transplantation (includes reimplantation from one site to another and splinting and/or stabilization) | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                                                                                 |
| D7280    | Oral & maxillofacial surgery | Surgical access of unerupted tooth                                                                          | Not a covered benefit.                                                                                                                               | Once per permanent tooth (1 through 32) per lifetime.                                                                                                | Tooth identification                                                                 |
| D7282    | Oral & maxillofacial surgery | Mobilization of erupted or mal-positioned tooth to aid eruption                                             | Not a covered benefit.                                                                                                                               | Once per permanent tooth (1 through 32) per lifetime.                                                                                                | Tooth identification                                                                 |
| D7283    | Oral & maxillofacial surgery | Placement of a device to facilitate eruption of impacted tooth                                              | Once per tooth per lifetime and covered only with approved medically necessary orthodontics.                                                         | Once per tooth per lifetime.                                                                                                                         | Tooth identification                                                                 |
| D7284    | Oral & maxillofacial surgery | Excisional biopsy of minor salivary glands                                                                  | Individual consideration.                                                                                                                            | Individual consideration.                                                                                                                            | Pathology report                                                                     |
| D7285    | Oral & maxillofacial surgery | Incisional biopsy of oral tissue – hard (bone, tooth)                                                       | Not a covered benefit.                                                                                                                               | Individual consideration.                                                                                                                            | Pathology report                                                                     |
| D7286    | Oral & maxillofacial surgery | Incisional biopsy of oral tissue – soft                                                                     | Not a covered benefit.                                                                                                                               | Individual consideration.                                                                                                                            | Pathology report                                                                     |

| CDT Code | ADA Category                 | Description of Service                                                                           | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements                                                                              |
|----------|------------------------------|--------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------|
| D7287    | Oral & maxillofacial surgery | Cytology exfoliative sample collection                                                           | Not a covered benefit.                       | Individual consideration.                      | Pathology report                                                                                     |
| D7288    | Oral & maxillofacial surgery | Brush biopsy – transepithelial sample collection                                                 | Not a covered benefit.                       | Individual consideration.                      | Pathology report                                                                                     |
| D7290    | Oral & maxillofacial surgery | Surgical repositioning of teeth – grafting procedures are additional                             | Not a covered benefit.                       | Individual consideration.                      | Tooth identification<br><br>Detailed narrative                                                       |
| D7291    | Oral & maxillofacial surgery | Transseptal fiberotomy/supra crestal fiberotomy, by report                                       | Not a covered benefit.                       | Individual consideration.                      | Tooth identification<br><br>Detailed narrative<br><br>Include orthodontic history                    |
| D7292    | Oral & maxillofacial surgery | Placement of temporary anchorage device [screw retained plate] requiring flap                    | Not a covered benefit.                       | Not a covered benefit.                         | None                                                                                                 |
| D7293    | Oral & maxillofacial surgery | Placement of temporary anchorage device requiring flap                                           | Not a covered benefit.                       | Not a covered benefit.                         | None                                                                                                 |
| D7294    | Oral & maxillofacial surgery | Placement of temporary anchorage device without flap                                             | Not a covered benefit.                       | Not a covered benefit.                         | None                                                                                                 |
| D7295    | Oral & maxillofacial surgery | Harvest of bone for use in autogenous grafting procedures                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                                                                                                 |
| D7296    | Oral & maxillofacial surgery | Corticotomy one to three teeth                                                                   | Not a covered benefit.                       | Not a covered benefit.                         | None                                                                                                 |
| D7297    | Oral & maxillofacial surgery | Corticotomy four or more teeth                                                                   | Not a covered benefit.                       | Not a covered benefit.                         | None                                                                                                 |
| D7298    | Oral & maxillofacial surgery | Removal of temporary anchorage device [screw retained plate], requiring flap                     | Not a covered benefit.                       | Not a covered benefit.                         | None                                                                                                 |
| D7299    | Oral & maxillofacial surgery | Removal of temporary anchorage device, requiring flap                                            | Not a covered benefit.                       | Not a covered benefit.                         | None                                                                                                 |
| D7300    | Oral & maxillofacial surgery | Removal of temporary anchorage device without flap                                               | Not a covered benefit.                       | Not a covered benefit.                         | None                                                                                                 |
| D7310    | Oral & maxillofacial surgery | Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant | Once per quadrant per lifetime.              | Once per quadrant per lifetime.                | Quadrant Identification<br><br>Detailed narrative or progress notes<br><br>Pre-operative radiographs |

| CDT Code | ADA Category                 | Description of Service                                                                                                                                                         | Pediatric EHB Procedure Guidelines Ages 0-19                                                 | Adult EHB Procedure Guidelines Ages 19 & older                                               | Submission Requirements                                                                                                                 |
|----------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| D7311    | Oral & maxillofacial surgery | Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant                                                                               | Once per quadrant per lifetime.                                                              | Once per quadrant per lifetime.                                                              | Quadrant Identification<br><br>Detailed narrative or progress notes<br><br>Pre-operative radiographs                                    |
| D7320    | Oral & maxillofacial surgery | Alveoloplasty not in conjunction with extractions –four or more teeth or tooth spaces, per quadrant                                                                            | Once per quadrant per lifetime.                                                              | Once per quadrant per lifetime.                                                              | Quadrant Identification<br><br>Detailed narrative or progress notes<br><br>Pre-operative radiographs                                    |
| D7321    | Oral & maxillofacial surgery | Alveoloplasty, not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant                                                                          | Once per quadrant per lifetime.                                                              | Once per quadrant per lifetime.                                                              | Quadrant Identification<br><br>Tooth spaces identification<br><br>Detailed narrative or progress notes<br><br>Pre-operative radiographs |
| D7340    | Oral & maxillofacial surgery | Vestibuloplasty – ridge extension (secondary epithelialization)                                                                                                                | Individual consideration. Services must be rendered by an oral surgeon for benefit coverage. | Individual consideration. Services must be rendered by an oral surgeon for benefit coverage. | Arch identification                                                                                                                     |
| D7350    | Oral & maxillofacial surgery | Vestibuloplasty – ridge extension (incl. soft tissue grafts, muscle re-attachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) | Individual consideration. Services must be rendered by an oral surgeon for benefit coverage. | Individual consideration. Services must be rendered by an oral surgeon for benefit coverage. | Arch identification                                                                                                                     |
| D7410    | Oral & maxillofacial surgery | Excision of benign lesion, up to 1.25 cm                                                                                                                                       | Individual consideration.                                                                    | Individual consideration.                                                                    | Pathology report                                                                                                                        |
| D7411    | Oral & maxillofacial surgery | Excision of benign lesion greater than 1.25 cm                                                                                                                                 | Individual consideration.                                                                    | Individual consideration.                                                                    | Pathology report                                                                                                                        |
| D7412    | Oral & maxillofacial surgery | Excision of benign lesion, complicated                                                                                                                                         | Not a covered benefit.                                                                       | Individual consideration.                                                                    | Pathology report                                                                                                                        |

| CDT Code | ADA Category                 | Description of Service                                                               | Pediatric EHB Procedure Guidelines Ages 0-19                                                 | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements                                            |
|----------|------------------------------|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|------------------------------------------------|--------------------------------------------------------------------|
| D7413    | Oral & maxillofacial surgery | Excision of malignant lesion up to 1.25 cm                                           | Not a covered benefit.                                                                       | Individual consideration.                      | Pathology report                                                   |
| D7414    | Oral & maxillofacial surgery | Excision of malignant lesion greater than 1.25 cm                                    | Not a covered benefit.                                                                       | Individual consideration.                      | Pathology report                                                   |
| D7415    | Oral & maxillofacial surgery | Excision of malignant lesion, complicated                                            | Not a covered benefit.                                                                       | Individual consideration.                      | Pathology report                                                   |
| D7440    | Oral & maxillofacial surgery | Excision of malignant tumor – lesion diameter up to 1.25 cm                          | Not a covered benefit.                                                                       | Individual consideration.                      | Pathology report                                                   |
| D7441    | Oral & maxillofacial surgery | Excision of malignant tumor – lesion diameter greater than 1.25 cm                   | Not a covered benefit.                                                                       | Individual consideration.                      | Pathology report                                                   |
| D7450    | Oral & maxillofacial surgery | Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm          | Individual consideration; services must be rendered by an oral surgeon for benefit coverage. | Individual consideration.                      | Pathology report                                                   |
| D7451    | Oral & maxillofacial surgery | Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm   | Individual consideration; services must be rendered by an oral surgeon for benefit coverage. | Individual consideration.                      | Pathology report                                                   |
| D7460    | Oral & maxillofacial surgery | Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 cm       | Individual consideration; services must be rendered by an oral surgeon for benefit coverage. | Individual consideration.                      | Pathology report                                                   |
| D7461    | Oral & maxillofacial surgery | Removal of benign nonodontogenic cyst or tumor– lesion diameter greater than 1.25 cm | Individual consideration; services must be rendered by an oral surgeon for benefit coverage. | Individual consideration.                      | Pathology report                                                   |
| D7465    | Oral & maxillofacial surgery | Destruction of lesion(s) by physical or chemical methods, by report                  | Not a covered benefit.                                                                       | Not a covered benefit.                         | None                                                               |
| D7471    | Oral & maxillofacial surgery | Removal of lateral exostosis (maxilla or mandible)                                   | Services must be rendered by an oral surgeon for benefit coverage.                           | Once per arch per lifetime.                    | Arch identification                                                |
| D7472    | Oral & maxillofacial surgery | Removal of torus palatinus                                                           | Not a covered benefit.                                                                       | Once per arch per lifetime                     | Arch identification                                                |
| D7473    | Oral & maxillofacial surgery | Removal of torus mandibularis                                                        | Not a covered benefit.                                                                       | Once per quadrant per lifetime.                | Quadrant identification                                            |
| D7485    | Oral & maxillofacial surgery | Reduction of osseous tuberosity                                                      | Not a covered benefit.                                                                       | Once per upper quadrant per lifetime.          | Quadrant identification                                            |
| D7490    | Oral & maxillofacial surgery | Radical resection of maxilla or mandible                                             | Not a covered benefit.                                                                       | Not a covered benefit.                         | None                                                               |
| D7509    | Oral & maxillofacial surgery | Marsupialization of odontogenic cyst                                                 | Not a covered benefit.                                                                       | Individual consideration.                      | Tooth identification<br><br>Detailed narrative or operative report |

| CDT Code | ADA Category                 | Description of Service                                                                                               | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements                                         |
|----------|------------------------------|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------------|-----------------------------------------------------------------|
| D7510    | Oral & maxillofacial surgery | Incision and drainage of abscess – intraoral soft tissue                                                             | Not a covered benefit.                       | Individual consideration.                      | Tooth identification<br>Detailed narrative                      |
| D7511    | Oral & maxillofacial surgery | Incision and drainage of abscess – intraoral soft tissue, complicated (includes drainage of multiple fascial spaces) | Not a covered benefit.                       | Individual consideration.                      | Tooth identification<br>Detailed narrative                      |
| D7520    | Oral & maxillofacial surgery | Incision and drainage of abscess – extraoral soft tissue                                                             | Not a covered benefit.                       | Individual consideration.                      | Detailed narrative                                              |
| D7521    | Oral & maxillofacial surgery | Incision and drainage of abscess – extraoral soft tissue, complicated (includes drainage of multiple fascial spaces) | Not a covered benefit.                       | Individual consideration.                      | Detailed narrative                                              |
| D7530    | Oral & maxillofacial surgery | Removal of foreign body, mucosa, skin, or subcutaneous alveolar tissue                                               | Not a covered benefit.                       | Individual consideration.                      | Pathology report<br>Operative report                            |
| D7540    | Oral & maxillofacial surgery | Removal of reaction-producing foreign bodies, musculoskeletal system                                                 | Not a covered benefit.                       | Individual consideration.                      | Pathology report<br>Operative report                            |
| D7550    | Oral & maxillofacial surgery | Partial ostectomy/ sequestrectomy for removal of non-vital bone                                                      | Not a covered benefit.                       | Individual consideration.                      | Pathology report<br>Operative report                            |
| D7560    | Oral & maxillofacial surgery | Maxillary sinusotomy for removal of tooth fragment or foreign body                                                   | Not a covered benefit.                       | Individual consideration.                      | Operative report<br>Arch identification                         |
| D7610    | Oral & maxillofacial surgery | Maxilla – open reduction (teeth immobilized, if present)                                                             | Not a covered benefit.                       | Individual consideration.                      | Panoramic radiograph<br>Operative report<br>Arch identification |
| D7620    | Oral & maxillofacial surgery | Maxilla – closed reduction (teeth immobilized, if present)                                                           | Not a covered benefit.                       | Individual consideration.                      | Panoramic radiograph<br>Operative report<br>Arch identification |
| D7630    | Oral & maxillofacial surgery | Mandible – open reduction (teeth immobilized, if present)                                                            | Not a covered benefit.                       | Individual consideration.                      | Panoramic radiograph                                            |

| CDT Code | ADA Category                 | Description of Service                                                              | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements                                         |
|----------|------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------------|-----------------------------------------------------------------|
|          |                              |                                                                                     |                                              |                                                | Operative report<br>Arch identification                         |
| D7640    | Oral & maxillofacial surgery | Mandible – closed reduction (teeth immobilized, if present)                         | Not a covered benefit.                       | Individual consideration.                      | Panoramic radiograph<br>Operative report<br>Arch identification |
| D7650    | Oral & maxillofacial surgery | Malar and/or zygomatic arch – open reduction                                        | Not a covered benefit.                       | Individual consideration.                      | Panoramic radiograph<br>Operative report<br>Arch identification |
| D7660    | Oral & maxillofacial surgery | Malar and/or zygomatic arch – closed reduction                                      | Not a covered benefit.                       | Individual consideration.                      | Panoramic radiograph<br>Operative report<br>Arch identification |
| D7670    | Oral & maxillofacial surgery | Alveolus – closed reduction, may include stabilization of teeth                     | Not a covered benefit.                       | Individual consideration.                      | Panoramic radiograph<br>Operative report<br>Arch identification |
| D7671    | Oral & maxillofacial surgery | Alveolus – open reduction, may include stabilization of teeth                       | Not a covered benefit.                       | Individual consideration.                      | Panoramic radiograph<br>Operative report<br>Arch identification |
| D7680    | Oral & maxillofacial surgery | Facial bones – complicated reduction with fixation and multiple surgical approaches | Not a covered benefit.                       | Individual consideration.                      | Panoramic radiograph<br>Operative report                        |

| <b>CDT Code</b> | <b>ADA Category</b>          | <b>Description of Service</b>                    | <b>Pediatric EHB Procedure Guidelines Ages 0-19</b> | <b>Adult EHB Procedure Guidelines Ages 19 &amp; older</b> | <b>Submission Requirements</b>                                          |
|-----------------|------------------------------|--------------------------------------------------|-----------------------------------------------------|-----------------------------------------------------------|-------------------------------------------------------------------------|
| D7710           | Oral & maxillofacial surgery | Maxilla – open reduction, stabilization of teeth | Not a covered benefit.                              | Individual consideration.                                 | Panoramic radiograph<br><br>Operative report<br><br>Arch identification |
| D7720           | Oral & maxillofacial surgery | Maxilla – closed reduction                       | Not a covered benefit.                              | Individual consideration.                                 | Panoramic radiograph<br><br>Operative report<br><br>Arch identification |
| D7730           | Oral & maxillofacial surgery | Mandible – open reduction                        | Not a covered benefit.                              | Individual consideration.                                 | Panoramic radiograph<br><br>Operative report<br><br>Arch identification |
| D7740           | Oral & maxillofacial surgery | Mandible – closed reduction                      | Not a covered benefit.                              | Individual consideration.                                 | Panoramic radiograph<br><br>Operative report<br><br>Arch identification |
| D7750           | Oral & maxillofacial surgery | Malar and/or zygomatic arch – open reduction     | Not a covered benefit.                              | Individual consideration.                                 | Panoramic radiograph<br><br>Operative report<br><br>Arch identification |
| D7760           | Oral & maxillofacial surgery | Malar and/or zygomatic arch – closed reduction   | Not a covered benefit.                              | Individual consideration.                                 | Panoramic radiograph<br><br>Operative report<br><br>Arch identification |
| D7770           | Oral & maxillofacial surgery | Alveolus – open reduction stabilization of teeth | Not a covered benefit.                              | Individual consideration.                                 | Panoramic radiograph                                                    |

| CDT Code | ADA Category                 | Description of Service                                                              | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements                                         |
|----------|------------------------------|-------------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------------|-----------------------------------------------------------------|
|          |                              |                                                                                     |                                              |                                                | Operative report<br>Arch identification                         |
| D7771    | Oral & maxillofacial surgery | Alveolus – closed reduction, stabilization of teeth                                 | Not a covered benefit.                       | Individual consideration.                      | Panoramic radiograph<br>Operative report<br>Arch identification |
| D7780    | Oral & maxillofacial surgery | Facial bones – complicated reduction with fixation and multiple surgical approaches | Not a covered benefit.                       | Individual consideration.                      | None                                                            |
| D7810    | Oral & maxillofacial surgery | Open reduction of dislocation                                                       | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7820    | Oral & maxillofacial surgery | Closed reduction of dislocation                                                     | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7830    | Oral & maxillofacial surgery | Manipulation under anesthesia                                                       | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7840    | Oral & maxillofacial surgery | Condylectomy                                                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7850    | Oral & maxillofacial surgery | Surgical disectomy; with or without implant                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7852    | Oral & maxillofacial surgery | Disc repair                                                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7854    | Oral & maxillofacial surgery | Synovectomy                                                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7856    | Oral & maxillofacial surgery | Myotomy                                                                             | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7858    | Oral & maxillofacial surgery | Joint reconstruction                                                                | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7860    | Oral & maxillofacial surgery | Arthrotomy                                                                          | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7865    | Oral & maxillofacial surgery | Arthroplasty                                                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7870    | Oral & maxillofacial surgery | Arthrocentesis                                                                      | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7871    | Oral & maxillofacial surgery | Non-anthroscopic lysis and lavage                                                   | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |
| D7872    | Oral & maxillofacial surgery | Arthroscopy – diagnosis, with or without biopsy                                     | Not a covered benefit.                       | Not a covered benefit.                         | None                                                            |

| CDT Code | ADA Category                 | Description of Service                                                                             | Pediatric EHB Procedure Guidelines Ages 0-19 | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements |
|----------|------------------------------|----------------------------------------------------------------------------------------------------|----------------------------------------------|------------------------------------------------|-------------------------|
| D7873    | Oral & maxillofacial surgery | Arthroscopy – surgical, lavage and lysis of adhesions                                              | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7874    | Oral & maxillofacial surgery | Arthroscopy – surgical, disc repositioning and stabilization                                       | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7875    | Oral & maxillofacial surgery | Arthroscopy – surgical, synovectomy                                                                | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7876    | Oral & maxillofacial surgery | Arthroscopy – surgical, disectomy                                                                  | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7877    | Oral & maxillofacial surgery | Arthroscopy – surgical, debridement                                                                | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7880    | Oral & maxillofacial surgery | Occlusal orthotic device, by report                                                                | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7881    | Oral & maxillofacial surgery | Occlusal orthotic device adjustment                                                                | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7899    | Oral & maxillofacial surgery | Unspecified TMD therapy, by report                                                                 | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7910    | Oral & maxillofacial surgery | Suture of recent small wounds up to 5 cm                                                           | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7911    | Oral & maxillofacial surgery | Complicated suture – up to 5 cm                                                                    | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7912    | Oral & maxillofacial surgery | Complicated suture – greater than 5 cm                                                             | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7920    | Oral & maxillofacial surgery | Skin grafts (identify defect covered, location, and type of graft)                                 | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7921    | Oral & maxillofacial surgery | Collection and application of autologous blood concentrate product                                 | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7922    | Oral & maxillofacial surgery | Placement on intra-socket biological dressing to aid in hemostasis or clot stabilization, per site | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7939    | Oral & maxillofacial surgery | Indexing for osteotomy using dynamic robotic assisted or dynamic navigation                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7940    | Oral & maxillofacial surgery | Osteoplasty – for orthognathic deformities                                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7941    | Oral & maxillofacial surgery | Osteotomy – mandibular rami                                                                        | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7943    | Oral & maxillofacial surgery | Osteotomy – mandibular rami with bone graft; includes obtaining the graft                          | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7944    | Oral & maxillofacial surgery | Osteotomy – segmented or sub-apical, per sextant or quadrant                                       | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7945    | Oral & maxillofacial surgery | Osteotomy – body of mandible                                                                       | Not a covered benefit.                       | Not a covered benefit.                         | None                    |
| D7946    | Oral & maxillofacial surgery | LeFort I (maxilla – total)                                                                         | Not a covered benefit.                       | Not a covered benefit.                         | None                    |

| CDT Code | ADA Category                 | Description of Service                                                                                               | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                    | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                                  | Submission Requirements                        |
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| D7947    | Oral & maxillofacial surgery | LeFort I (maxilla – segmented)                                                                                       | Not a covered benefit.                                                                                                                                          | Not a covered benefit.                                                                                                                                          | None                                           |
| D7948    | Oral & maxillofacial surgery | LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft       | Not a covered benefit.                                                                                                                                          | Not a covered benefit.                                                                                                                                          | None                                           |
| D7949    | Oral & maxillofacial surgery | LeFort II or LeFort II – with bone graft                                                                             | Not a covered benefit.                                                                                                                                          | Not a covered benefit.                                                                                                                                          | None                                           |
| D7950    | Oral & maxillofacial surgery | Osseous, osteoperiosteal, or cartilage graft of the mandible or facial bones, autogenous or nonautogenous, by report | Not a covered benefit.                                                                                                                                          | Not a covered benefit.                                                                                                                                          | None                                           |
| D7951    | Oral & maxillofacial surgery | Sinus augmentation with bone or bone substitutes via a lateral open approach                                         | Not a covered benefit.                                                                                                                                          | Not a covered benefit.                                                                                                                                          | None                                           |
| D7952    | Oral & maxillofacial surgery | Sinus augmentation via a vertical approach                                                                           | Not a covered benefit.                                                                                                                                          | Not a covered benefit.                                                                                                                                          | None                                           |
| D7953    | Oral & maxillofacial surgery | Bone replacement graft for ridge preservation – per site                                                             | Not a covered benefit.                                                                                                                                          | Not a covered benefit.                                                                                                                                          | None                                           |
| D7955    | Oral & maxillofacial surgery | Repair of maxillofacial soft and/or hard tissue defect                                                               | Not a covered benefit.                                                                                                                                          | Not a covered benefit.                                                                                                                                          | None                                           |
| D7956    | Oral & maxillofacial surgery | Guided tissue regeneration, edentulous area – resorbable barrier, per site                                           | Not a covered benefit.                                                                                                                                          | Not a covered benefit.                                                                                                                                          | None                                           |
| D7957    | Oral & maxillofacial surgery | Guided tissue regeneration, edentulous area – non-resorbable barrier, per site                                       | Not a covered benefit.                                                                                                                                          | Not a covered benefit.                                                                                                                                          | None                                           |
| D7961    | Oral & maxillofacial surgery | Buccal/labial frenectomy (frenulectomy)                                                                              | D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service. | D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service. | Tooth identification<br><br>Detailed narrative |
| D7962    | Oral & maxillofacial surgery | Lingual frenectomy (frenulectomy)                                                                                    | D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service. | D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service. | Tooth identification<br><br>Detailed narrative |
| D7963    | Oral & maxillofacial surgery | Frenuloplasty                                                                                                        | D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service. | D7961, D7962 or D7963 covered once per site per lifetime. Not allowed when performed in conjunction with soft tissue graft; same site and same date of service. | Tooth identification<br><br>Detailed narrative |
| D7970    | Oral & maxillofacial surgery | Excision of hyperplastic tissue – per arch                                                                           | Not payable on the same date of service as an extraction in the same area.                                                                                      | Individual consideration.                                                                                                                                       | Arch identification                            |

| CDT Code | ADA Category                 | Description of Service                                                               | Pediatric EHB Procedure Guidelines Ages 0-19                               | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements                                                |
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| D7971    | Oral & maxillofacial surgery | Excision of pericoronal gingiva                                                      | Not a covered benefit.                                                     | Individual consideration.                      | Tooth identification                                                   |
| D7972    | Oral & maxillofacial surgery | Surgical reduction of fibrous tuberosity                                             | Not a covered benefit.                                                     | Once per upper quadrant per lifetime.          | Quadrant identification                                                |
| D7979    | Oral & maxillofacial surgery | Non-surgical sialolithotomy                                                          | Not a covered benefit.                                                     | Not a covered benefit.                         | None                                                                   |
| D7980    | Oral & maxillofacial surgery | Sialolithotomy                                                                       | Not a covered benefit.                                                     | Individual consideration.                      | Detailed narrative                                                     |
| D7981    | Oral & maxillofacial surgery | Excision of salivary gland, by report                                                | Not a covered benefit.                                                     | Individual consideration.                      | Detailed narrative                                                     |
| D7982    | Oral & maxillofacial surgery | Sialodochoplasty                                                                     | Not a covered benefit.                                                     | Individual consideration.                      | Detailed narrative                                                     |
| D7983    | Oral & maxillofacial surgery | Closure of salivary fistula                                                          | Not a covered benefit.                                                     | Individual consideration.                      | Detailed narrative                                                     |
| D7990    | Oral & maxillofacial surgery | Emergency tracheotomy                                                                | Not a covered benefit.                                                     | Not a covered benefit.                         | None                                                                   |
| D7991    | Oral & maxillofacial surgery | Coronoidectomy                                                                       | Not a covered benefit.                                                     | Not a covered benefit.                         | None                                                                   |
| D7993    | Oral & maxillofacial surgery | Surgical placement of craniofacial implant – extra oral                              | Not a covered benefit.                                                     | Not a covered benefit.                         | None                                                                   |
| D7994    | Oral & maxillofacial surgery | Surgical placement: zygomatic implant                                                | Not a covered benefit.                                                     | Not a covered benefit.                         | None                                                                   |
| D7995    | Oral & maxillofacial surgery | Synthetic graft – mandible or facial bones, by report                                | Not a covered benefit.                                                     | Not a covered benefit.                         | None                                                                   |
| D7996    | Oral & maxillofacial surgery | Implant – mandible for amentation purposes (excluding alveolar ridge), by report     | Not a covered benefit.                                                     | Not a covered benefit.                         | None                                                                   |
| D7997    | Oral & maxillofacial surgery | Appliance removal (not by dentist who placed appliance), includes removal of archbar | Not a covered benefit.                                                     | Individual consideration.                      | Detailed narrative                                                     |
| D7998    | Oral & maxillofacial surgery | Intraoral placement of a fixation device not in conjunction with a fracture          | Not a covered benefit.                                                     | Not a covered benefit.                         | None                                                                   |
| D7999    | Oral & maxillofacial surgery | Unspecified oral surgery procedure, by report                                        | Individual consideration.                                                  | Individual consideration.                      | Tooth identification<br><br>Detailed narrative<br><br>Operative report |
| D8010    | Orthodontics                 | Limited orthodontic treatment of the primary dentition                               | Once per child per lifetime; services must be provided by an orthodontist. | Not a covered benefit.                         | Prior authorization                                                    |
| D8020    | Orthodontics                 | Limited orthodontic treatment of the transitional dentition                          | Once per child per lifetime; services must be provided by an orthodontist. | Not a covered benefit.                         | Prior authorization                                                    |

| CDT Code | ADA Category | Description of Service                                                                   | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                                                                                                                             | Adult EHB Procedure Guidelines Ages 19 & older | Submission Requirements |
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| D8030    | Orthodontics | Limited orthodontic treatment of the adolescent dentition                                | Not a covered benefit.                                                                                                                                                                                                                                   | Not a covered benefit.                         | None                    |
| D8040    | Orthodontics | Limited orthodontic treatment of the adult dentition                                     | Not a covered benefit.                                                                                                                                                                                                                                   | Not a covered benefit.                         | None                    |
| D8070    | Orthodontics | Comprehensive orthodontic treatment of transitional dentition                            | Not a covered benefit.                                                                                                                                                                                                                                   | Not a covered benefit.                         | None                    |
| D8080    | Orthodontics | Comprehensive orthodontic treatment of adolescent dentition                              | Once per child per lifetime; services must be provided by an orthodontist.                                                                                                                                                                               | Not a covered benefit.                         | Prior authorization.    |
| D8090    | Orthodontics | Comprehensive orthodontic treatment of the adult dentition                               | Not a covered benefit.                                                                                                                                                                                                                                   | Not a covered benefit.                         | None                    |
| D8091    | Orthodontics | Comprehensive orthodontic treatment with orthognathic surgery                            | Once per child per lifetime; services must be provided by an orthodontist.                                                                                                                                                                               | Not a covered benefit.                         | Prior authorization.    |
| D8210    | Orthodontics | Removable appliance therapy                                                              | Not a covered benefit.                                                                                                                                                                                                                                   | Not a covered benefit.                         | None                    |
| D8220    | Orthodontics | Fixed appliance therapy                                                                  | Not a covered benefit.                                                                                                                                                                                                                                   | Not a covered benefit.                         | None                    |
| D8660    | Orthodontics | Pre-orthodontic treatment examination to monitor growth and development                  | Use for orthodontic work-up. Services must be rendered by orthodontist. Covered when prior auth for codes D8010, D8020 and D8080 is denied. Not covered and considered inclusive of D8010, D8020 and D8080 when prior auth for orthodontics is approved. | Not a covered benefit.                         | None                    |
| D8670    | Orthodontics | Periodic orthodontic treatment visit                                                     | Included in the allowance for the comprehensive treatment. Also covered for previously approved EHB take-over cases.                                                                                                                                     | Not a covered benefit.                         | None                    |
| D8671    | Orthodontics | Periodic orthodontic treatment visit associated with orthognathic surgery                | Included in the allowance for the comprehensive treatment. Also covered for previously approved EHB take-over cases.                                                                                                                                     | Not a covered benefit.                         | None                    |
| D8680    | Orthodontics | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) | Included in the allowance for the comprehensive treatment.                                                                                                                                                                                               | Not a covered benefit.                         | None                    |
| D8681    | Orthodontics | Removable orthodontic retainer adjustment                                                | Not a covered benefit.                                                                                                                                                                                                                                   | Not a covered benefit.                         | None                    |
| D8695    | Orthodontics | Removal of fixed orthodontic appliances for reasons other than completion of treatment   | Not a covered benefit.                                                                                                                                                                                                                                   | Not a covered benefit.                         | None                    |
| D8696    | Orthodontics | Repair of orthodontic appliance – maxillary                                              | Not a covered benefit.                                                                                                                                                                                                                                   | Not a covered benefit.                         | None                    |

| CDT Code | ADA Category       | Description of Service                                                                              | Pediatric EHB Procedure Guidelines Ages 0-19                                         | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                      | Submission Requirements                       |
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| D8697    | Orthodontics       | Repair of orthodontic appliance – mandibular                                                        | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D8698    | Orthodontics       | Re-cement or re-bond fixed retainer – maxillary                                                     | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D8699    | Orthodontics       | Re-cement or re-bond retainer – mandibular                                                          | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D8701    | Orthodontics       | Repair of fixed retainer, includes reattachment – maxillary                                         | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D8702    | Orthodontics       | Repair of fixed retainer, includes reattachment – mandibular                                        | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D8703    | Orthodontics       | Replacement of lost or broken retainer – maxillary                                                  | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D8704    | Orthodontics       | Replacement of lost or broken retainer – mandibular                                                 | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D8999    | Orthodontics       | Unspecified orthodontic procedure, by report. Use for procedures not adequately described by a code | Individual consideration.                                                            | Not a covered benefit.                                                                                                                              | Prior authorization<br><br>Detailed narrative |
| D9110    | Adjunctive general | Palliative treatment of dental pain – per visit                                                     | Other definitive medically necessary services may be provided during the same visit. | Considered inclusive when performed on the same day as other definitive services by same dentist/dental office, other than appropriate radiographs. | None                                          |
| D9120    | Adjunctive general | Fixed partial denture sectioning                                                                    | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D9130    | Adjunctive general | Temporomandibular joint dysfunction – non-invasive physical therapies                               | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D9210    | Adjunctive general | Local anesthesia not in conjunction with operative or surgical procedures                           | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D9211    | Adjunctive general | Regional block anesthesia                                                                           | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D9212    | Adjunctive general | Trigeminal division block anesthesia                                                                | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D9215    | Adjunctive general | Local anesthesia in conjunction with operative or surgical procedures                               | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D9219    | Adjunctive general | Evaluation for moderate sedation, deep sedation or general anesthesia                               | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D9222    | Adjunctive general | Deep sedation/general anesthesia – first 15 minutes                                                 | Covered when provided with covered surgical procedures.                              | Covered when provided with covered surgical procedures.                                                                                             | None                                          |
| D9223    | Adjunctive general | Deep sedation/general anesthesia – each subsequent 15 minute increment                              | Covered when provided with covered surgical procedures.                              | Covered when provided with covered surgical procedures.                                                                                             | None                                          |
| D9230    | Adjunctive general | Inhalation of nitrous oxide/analgesia, anxiolysis                                                   | Not a covered benefit.                                                               | Not a covered benefit.                                                                                                                              | None                                          |
| D9239    | Adjunctive general | Intravenous moderate (conscious) sedation/analgesia- first 15 minutes                               | Covered when provided with covered surgical procedures.                              | Covered when provided with covered surgical procedures.                                                                                             | None                                          |

| CDT Code | ADA Category       | Description of Service                                                                                        | Pediatric EHB Procedure Guidelines Ages 0-19                                                                               | Adult EHB Procedure Guidelines Ages 19 & older                     | Submission Requirements                                                                                                                                       |
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| D9243    | Adjunctive general | Intravenous moderate (conscious) sedation/ analgesia – each subsequent 15 minute increment                    | Covered when provided with covered surgical procedures.                                                                    | Covered when provided with covered surgical procedures.            | None                                                                                                                                                          |
| D9248    | Adjunctive general | Non-intravenous (conscious) sedation.                                                                         | Covered when provided with covered surgical procedures.                                                                    | Not a covered benefit.                                             | None                                                                                                                                                          |
| D9310    | Adjunctive general | Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician | Not a covered benefit.                                                                                                     | Covered benefit only when documented as used for a second opinion. | Detailed narrative including the referring dentist's name<br><br>Submit with both codes on the same claim: D9310 at the charge amount and D9999 at no charge. |
| D9311    | Adjunctive general | Consultation with a medical health care professional                                                          | Not a covered benefit.                                                                                                     | Not a covered benefit.                                             | None                                                                                                                                                          |
| D9410    | Adjunctive general | House call/extended care facility call                                                                        | One per facility per date of service. Claim must include place of service codes 03, 04, 12, 13, 14, 31, 32, 33, 34, or 99. | Not a covered benefit.                                             | Detailed narrative                                                                                                                                            |
| D9420    | Adjunctive general | Hospital or ambulatory surgical center call                                                                   | Not a covered benefit.                                                                                                     | Not a covered benefit.                                             | None                                                                                                                                                          |
| D9430    | Adjunctive general | Office visit for observation (during regularly scheduled hours) – no other services performed                 | Not a covered benefit.                                                                                                     | Not a covered benefit.                                             | None                                                                                                                                                          |
| D9440    | Adjunctive general | Office visit-after regularly scheduled hours                                                                  | Not a covered benefit.                                                                                                     | Not a covered benefit.                                             | None                                                                                                                                                          |
| D9450    | Adjunctive general | Case presentation, subsequent to detailed and extensive treatment planning                                    | Not a covered benefit.                                                                                                     | Not a covered benefit.                                             | None                                                                                                                                                          |
| D9610    | Adjunctive general | Therapeutic parenteral drug, single administration                                                            | Not a covered benefit.                                                                                                     | Not a covered benefit.                                             | None                                                                                                                                                          |
| D9612    | Adjunctive general | Therapeutic parenteral drugs, two or more administrations, different medications                              | Not a covered benefit.                                                                                                     | Not a covered benefit.                                             | None                                                                                                                                                          |
| D9613    | Adjunctive general | Infiltration of sustained release therapeutic drug, per quadrant                                              | Not a covered benefit.                                                                                                     | Not a covered benefit.                                             | None                                                                                                                                                          |
| D9630    | Adjunctive general | Other drugs and/or medicaments, by report                                                                     | Not a covered benefit.                                                                                                     | Not a covered benefit                                              | None                                                                                                                                                          |
| D9910    | Adjunctive general | Application of desensitizing medicament                                                                       | Not a covered benefit.                                                                                                     | Once per 12 months.                                                | None                                                                                                                                                          |
| D9911    | Adjunctive general | Application of desensitizing resin for cervical and/or root surface, per tooth                                | Not a covered benefit.                                                                                                     | Once per permanent tooth (1 through 32) per 48 months.             | Tooth identification                                                                                                                                          |

| CDT Code | ADA Category       | Description of Service                                                        | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                         | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                       | Submission Requirements |
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| D9912    | Adjunctive general | Pre-visit patient screening                                                   | Not a covered benefit (included in the primary service that is being rendered).                                                                      | Not a covered benefit (included in the primary service that is being rendered).                                                                      | None                    |
| D9913    | Adjunctive general | Administration of neuromodulators                                             | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D9914    | Adjunctive general | Administration of dermal fillers                                              | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D9920    | Adjunctive general | Behavior management, by report                                                | One per day per provider or location.                                                                                                                | Not a covered benefit.                                                                                                                               | Detailed narrative      |
| D9930    | Adjunctive general | Treatment of complications (post-surgical) – unusual circumstances, by report | Individual consideration.                                                                                                                            | Individual consideration.                                                                                                                            | Detailed narrative      |
| D9932    | Adjunctive general | Cleaning and inspection of removable complete denture, maxillary              | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D9933    | Adjunctive general | Cleaning and inspection of removable complete denture, mandibular             | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D9934    | Adjunctive general | Cleaning and inspection of removable partial denture, maxillary               | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D9935    | Adjunctive general | Cleaning and inspection of removable partial denture, mandibular              | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D9938    | Adjunctive general | Fabrication of a custom removable clear plastic temporary aesthetic appliance | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D9939    | Adjunctive general | Placement of a custom removable clear plastic temporary aesthetic appliance   | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D9941    | Adjunctive general | Fabrication of athletic mouthguard                                            | Covered benefit.                                                                                                                                     | Not a covered benefit.                                                                                                                               | None                    |
| D9942    | Adjunctive general | Repair and/or reline of occlusal guard                                        | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D9943    | Adjunctive general | Occlusal guard adjustment                                                     | Not a covered benefit.                                                                                                                               | Not a covered benefit.                                                                                                                               | None                    |
| D9944    | Adjunctive general | Occlusal guard – hard appliance, full arch                                    | One D9944, D9945, or D9946 covered once per calendar year.                                                                                           | Not a covered benefit                                                                                                                                | None                    |
| D9945    | Adjunctive general | Occlusal guard – soft appliance, full arch                                    | One D9944, D9945, or D9946 covered once per calendar year.                                                                                           | Not a covered benefit                                                                                                                                | None                    |
| D9946    | Adjunctive general | Occlusal guard – hard appliance, partial arch                                 | One D9944, D9945, or D9946 covered once per calendar year.                                                                                           | Not a covered benefit                                                                                                                                | None                    |
| D9947    | Sleep apnea        | Custom sleep apnea appliance fabrication and placement                        | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | None                    |
| D9948    | Sleep apnea        | Adjustment of custom sleep apnea appliance                                    | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Check with patient's medical insurer for possible coverage.        | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | None                    |

| CDT Code | ADA Category       | Description of Service                                                                                | Pediatric EHB Procedure Guidelines Ages 0-19                                                                                                  | Adult EHB Procedure Guidelines Ages 19 & older                                                                                                       | Submission Requirements |
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| D9949    | Sleep apnea        | Repair of custom sleep apnea appliance                                                                | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Check with patient's medical insurer for possible coverage. | Not a covered benefit under Blue Cross Blue Shield of Massachusetts dental plans. Please check with patient's medical insurer for possible coverage. | None                    |
| D9950    | Adjunctive general | Occlusion analysis – mounted case                                                                     | Considered inclusive of rehabilitative services. Not a covered benefit in any other circumstances.                                            | Considered inclusive of rehabilitative services. Not a covered benefit in any other circumstances.                                                   | None                    |
| D9951    | Adjunctive general | Occlusal adjustment – limited                                                                         | Not a covered benefit                                                                                                                         | Once per quadrant per 24 months                                                                                                                      | Quadrant identification |
| D9952    | Adjunctive general | Occlusal adjustment – complete                                                                        | Not a covered benefit                                                                                                                         | Once per 24 months                                                                                                                                   | None                    |
| D9953    | Sleep apnea        | Reline custom sleep apnea appliance (indirect)                                                        | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9954    | Sleep apnea        | Fabrication and delivery of oral appliance therapy (OAT) morning repositioning device                 | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9955    | Sleep apnea        | Oral appliance therapy (OAT) titration visit                                                          | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9956    | Sleep apnea        | Administration of home sleep apnea test                                                               | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9957    | Sleep apnea        | Screening for sleep related breathing disorders                                                       | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9959    | Sleep apnea        | Unspecified sleep apnea services procedure, by report                                                 | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9961    | Adjunctive general | Duplicate/copy patient's records                                                                      | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9970    | Adjunctive general | Enamel microabrasion                                                                                  | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9971    | Adjunctive general | Odontoplasty – per tooth                                                                              | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9972    | Adjunctive general | External bleaching – per arch – in office                                                             | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9973    | Adjunctive general | External bleaching – per tooth                                                                        | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9974    | Adjunctive general | Internal bleaching – per tooth                                                                        | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9975    | Adjunctive general | External bleaching for home application, per arch; includes materials and fabrication of custom trays | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9985    | Adjunctive general | Sales tax                                                                                             | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9986    | Adjunctive general | Missed appointment                                                                                    | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9987    | Adjunctive general | Cancelled appointment                                                                                 | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9990    | Adjunctive general | Certified translation or sign language services – per visit                                           | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9991    | Adjunctive general | Dental case management – addressing appointment compliance barriers                                   | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |
| D9992    | Adjunctive general | Dental case management – care coordination                                                            | Not a covered benefit                                                                                                                         | Not a covered benefit                                                                                                                                | None                    |

| <b>CDT Code</b> | <b>ADA Category</b> | <b>Description of Service</b>                                    | <b>Pediatric EHB Procedure Guidelines Ages 0-19</b> | <b>Adult EHB Procedure Guidelines Ages 19 &amp; older</b> | <b>Submission Requirements</b> |
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| D9993           | Adjunctive general  | Dental case management – motivational interviewing               | Not a covered benefit                               | Not a covered benefit                                     | None                           |
| D9994           | Adjunctive general  | Dental case management – patient education                       | Not a covered benefit                               | Not a covered benefit                                     | None                           |
| D9995           | Adjunctive general  | Teledentistry synchronous                                        | Not a covered benefit                               | Not a covered benefit                                     | None                           |
| D9996           | Adjunctive general  | Teledentistry nonsynchronous                                     | Not a covered benefit                               | Not a covered benefit                                     | None                           |
| D9997           | Adjunctive general  | Dental case management – patients with special health care needs | Not a covered benefit                               | Not a covered benefit                                     | None                           |
| D9999           | Adjunctive general  | Unspecified adjunctive procedure by report                       | Individual consideration                            | Individual consideration                                  | Detailed narrative             |