

PTA15 (for certain Southeastern Pennsylvania Transit Authority [SEPTA] employees) – Plan Revised 02/15/12

Listed on the following pages of this Patient Charge Schedule are charges to be paid directly to you by the member for specific procedures. When using the Alternate Benefit Provisions, the listed copay for the applicable procedures may not apply. In the case of any discrepancy between this “At a Glance” booklet and the Patient Charge Schedule, the Patient Charge Schedule will prevail.

Different codes may be used to describe these covered procedures.

Procedure Code ¹		PTA15	Procedure Code ¹		PTA15
Diagnostic/Preventive					
D9310	Consultation (Normally Not The Same Dentist Who Provides The Treatment)	\$0	D0277	X-Rays (Bitewings, Vertical) – 7 to 8 Films	\$0
D0120	Periodic Oral Evaluation (Limit 2 Per 12 Months)	\$0	D0330	X-Rays (Panoramic Film) – (Limit 1 Every 3 Years) ■	\$0
D0140	Limited Oral Evaluation – Problem Focused (Limit 1 Per Dentist, Per 12 Months)	\$0	D0340	Cephalometric Film	\$0
D0145	Periodic Oral Evaluation (Limit 2 Per 12 Months) – Under Age 3	\$0	D0460	Pulp Vitality Tests	\$0
D0150	Comprehensive Oral Evaluation – New or Established Patient	\$0	D0470	Diagnostic Casts	\$0
D0160	Detailed and Extensive Oral Evaluation, Problem Focused, By Report	\$0	D1110	Cleaning – Adult (Limit 2 Per Year) ■	\$0
D0170	Re-evaluation – Problem Focused (Not Post-Operative Visit)	\$0	D1120	Cleaning – Child (Limit 2 Per Year) ■	\$0
D0210	X-Rays – Complete Series (Including Bitewings) (Limit 1 Every 3 Years) ■	\$0	D1203	Topical Fluoride Application – Child (Limit 2 Per Twelve Months Through Age 18) ■	\$0
D0220	X-Rays Intraoral Periapical, First Film	\$0	D1204	Topical Fluoride Application – Adult	\$0
D0230	X-Rays Intraoral Periapical, Each Additional Film	\$0	D1206	Topical Fluoride Varnish – (Limit 2 Per Twelve Months)	\$0
D0240	X-Rays Intraoral – Occlusal Film	\$0	D1330	Oral Hygiene Instructions	\$0
D0270	X-Rays (Bitewing) – Single Film	\$0	D1351	Sealant – Per Tooth (Up to Age 15) ■	\$0
D0272	X-Rays (Bitewings) – 2 Films	\$0	D1510	Space Maintainer – Fixed Unilateral (Age Limit Through Age 18)	\$0
D0273	X-Rays (Bitewings) – 3 Films	\$0	D1515	Space Maintainer – Fixed Bilateral (Age Limit Through Age 18)	\$0
D0274	X-Rays (Bitewings) – 4 Films	\$0	D1520	Space Maintainer – Removable – Unilateral (Age Limit Through Age 18)	\$0
			D1525	Space Maintainer – Removable – Bilateral (Age Limit Through Age 18)	\$0
			D1555	Removal of Fixed Space Maintainer	\$0

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Restorative (Fillings)	
D2140 Amalgam – 1 Surface, Primary or Permanent	\$0
D2150 Amalgam – 2 Surfaces, Primary or Permanent	\$0
D2160 Amalgam – 3 Surfaces, Primary or Permanent	\$0
D2161 Amalgam – 4 or More Surfaces, Primary or Permanent	\$0
D2330 Resin-Based Composite – 1 Surface, Anterior	\$0
D2331 Resin-Based Composite – 2 Surfaces, Anterior	\$0
D2332 Resin-Based Composite – 3 Surfaces, Anterior	\$0
D2335 Resin-Based Composite – 4 or More Surfaces or Involving Incisal Angle (Anterior)	\$0
D2390 Composite Crown, Anterior	\$0
D2391 Composite – 1 Surface, Posterior	\$0
D2392 Composite – 2 Surfaces, Posterior	\$0
D2393 Composite – 3 Surfaces, Posterior	\$0
D2394 Composite – 4 or More Surfaces, Posterior	\$0

Procedure Code ¹	PTA15
Crown and Bridge – All charges for crown and bridge are per unit (each replacement or supporting tooth equals 1 unit) – Replacement limit 1 every 5 years.♦ The charges below include the cost of base metal, noble metal, and high noble metal (precious). The charge for cast post and core includes the cost of high noble metal for an upgraded post and core. There is an additional charge of \$80 per tooth for porcelain restoration on molar teeth that is not included in the charges listed below for procedures identified with a ●. Porcelain/Ceramic substrate crowns and pontics on molar teeth are not covered and may be charged to the patient at your usual fee for procedures identified with a *.	
D2510 Inlay – Metallic – 1 Surface	\$213
D2520 Inlay – Metallic – 2 Surfaces	\$225
D2530 Inlay – Metallic – 3 or More Surfaces	\$243
D2542 Onlay – Metallic – 2 Surfaces	\$275
D2543 Onlay – Metallic – 3 Surfaces	\$288
D2544 Onlay – Metallic – 4 or More Surfaces	\$301
D2710 Crown – Resin-Based Composite (Indirect)	\$66
D2740 Crown – Porcelain/Ceramic Substrate *	\$225
D2750 Crown – Porcelain Fused to High Noble Metal ●	\$287
D2751 Crown – Porcelain Fused to Predominantly Base Metal ●	\$192
D2752 Crown – Porcelain Fused to Noble Metal ●	\$268
D2780 Crown – 3/4 Cast High Noble Metal	\$292
D2781 Crown – 3/4 Cast Predominantly Base Metal	\$222
D2782 Crown – 3/4 Cast Noble Metal	\$282

* Porcelain/Ceramic substrate crowns and pontics on molar teeth are not covered and may be charged to the patient at your usual fee for procedures identified with a *.

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Procedure Code ¹		PTA15	Procedure Code ¹		PTA15
Crown and Bridge ♦ ● * (continued)			D6092	Recement Implant/Abutment Supported Crown	\$0
D2783	Crown – 3/4 Porcelain/Ceramic *	\$222	D6093	Recement Implant/Abutment Supported Fixed Partial Denture	\$21
D2790	Crown – Full Cast High Noble Metal	\$282	D6210	Pontic – Cast High Noble Metal	\$284
D2791	Crown – Full Cast Predominantly Base Metal	\$191	D6211	Pontic – Cast Predominantly Base Metal	\$196
D2792	Crown – Full Cast Noble Metal	\$259	D6212	Pontic – Cast Noble Metal	\$266
D2799	Provisional Crown	\$0	D6240	Pontic – Porcelain Fused to High Noble Metal ●	\$285
D2910	Recement Inlay, Onlay or Veneer	\$0	D6241	Pontic – Porcelain Fused to Predominantly Base Metal ●	\$188
D2920	Recement Crown	\$0	D6242	Pontic – Porcelain Fused to Noble Metal ●	\$266
D2930	Prefabricated Stainless Steel Crown – Primary Tooth	\$0	D6245	Pontic – Porcelain/Ceramic *	\$188
D2931	Prefabricated Stainless Steel Crown – Permanent Tooth	\$0	D6740	Crown – Porcelain/Ceramic *	\$191
D2940	Protective Restoration	\$0	D6750	Crown – Porcelain Fused to High Noble Metal ●	\$287
D2950	Core Buildup, Including Any Pins	\$0	D6751	Crown – Porcelain Fused to Predominantly Base Metal ●	\$191
D2951	Pin Retention – Per Tooth, In Addition to Restoration	\$0	D6752	Crown – Porcelain Fused to Noble Metal ●	\$268
D2952	Cast Post and Core, In Addition to Crown	\$133	D6780	Crown – 3/4 Cast High Noble Metal	\$282
D2953	Each Additional Indirectly Fabricated Post – Same Tooth	\$102	D6781	Crown – 3/4 Cast Predominantly Base Metal	\$212
D2954	Prefabricated Post and Core In Addition to Crown	\$0	D6782	Crown – 3/4 Cast Noble Metal	\$272
D2955	Post Removal (Not in conjunction with Endodontic Therapy)	\$0	D6783	Crown – 3/4 Porcelain/Ceramic *	\$212
D2957	Each Additional Prefabricated Post – Same Tooth	\$0	D6790	Crown – Full Cast High Noble Metal	\$285
D2970	Temporary Crown (Fractured Tooth)	\$0	D6791	Crown – Full Cast Predominantly Base Metal	\$190
			D6792	Crown – Full Cast Noble Metal	\$270

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● There is an additional charge of \$80 per tooth for porcelain restoration on molar teeth that is not included in the charges for procedures identified with a ●.

♦ Limitations may be different for California residents.

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Crown and Bridge ♦ ● * (continued)		
D6930	Recement Fixed Partial Denture	\$21
D6970	Post and Core in Addition to Fixed Partial Denture Retainer, Indirectly Fabricated	\$70
D6972	Prefabricated Post and Core In Addition to Fixed Partial Denture Retainer	\$0
D6973	Core Buildup for Retainer, Including any Pins	\$0
D6976	Each Additional Indirectly Fabricated Post – Same Tooth	\$70
D6977	Each Additional Prefabricated Post – Same Tooth	\$0
Endodontics (Root canal treatment, excluding final restorations)		
D3110	Pulp Cap – Direct (Excluding Final Restoration)	\$0
D3120	Pulp Cap – Indirect (Excluding Final Restoration)	\$0
D3220	Therapeutic Pulpotomy – Removal of Pulp, Not Part of a Root Canal	\$0
D3221	Pulpal Debridement (Not to be Used When Root Canal is Done on the Same Day)	\$0
D3230	Pulpal Therapy (Resorbable Filling) – Anterior, Primary Tooth (Excluding Final Restorations)	\$0
D3240	Pulpal Therapy (Resorbable Filling) – Posterior, Primary Tooth (Excluding Final Restorations)	\$0
D3310	Anterior Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$0

Procedure Code ¹		PTA15
D3320	Bicuspid Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$0
D3330	Molar Root Canal (Permanent Tooth) (Excluding Final Restoration)	\$201
D3346	Retreatment of Previous Root Canal Therapy Anterior	\$0
D3347	Retreatment of Previous Root Canal Therapy Bicuspid	\$0
D3348	Retreatment of Previous Root Canal Therapy Molar	\$231
D3410	Apicoectomy/Periradicular Surgery Anterior	\$127
D3421	Apicoectomy/Periradicular Surgery – Bicuspid (First Root)	\$150
D3425	Apicoectomy/Periradicular Surgery – Molar (First Root)	\$160
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	\$56
D3430	Retrograde Filling – Per Root	\$30
D3450	Root Amputation – Per Root	\$81
D3920	Hemisection (Including any Root Removal), Not Including Root Canal Therapy	\$69
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	\$23
Periodontics (Treatment of Supporting Tissues [Gum and Bone] of the Teeth)		
D0180	Comprehensive Periodontal Evaluation – New or Established Patient	\$17
D4210	Gingivectomy or Gingivoplasty – 4 or More Teeth, Per Quadrant	\$80
D4211	Gingivectomy or Gingivoplasty – 1 to 3 Teeth, Per Quadrant	\$32
D4240	Gingival Flap, Including Root Planing – 4 or More Teeth, Per Quadrant	\$112
D4241	Gingival Flap, Including Root Planing – 1 to 3 Teeth, Per Quadrant	\$56

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Procedure Code ¹		PTA15
Periodontics (continued)		
D4245	Apically Positioned Flap	\$151
D4249	Clinical Crown Lengthening – Hard Tissue	\$112
D4260	Osseous Surgery – 4 or More Teeth or Bounded Spaces, Per Quadrant	\$226
D4261	Osseous Surgery – 1 to 3 Teeth, Per Quadrant	\$117
D4274	Distal or Proximal Wedge Procedure (When not performed in conjunction with surgical procedures in the same anatomical area)	\$136
D4341	Periodontal Scaling and Root Planing, 4 or More Teeth or Bounded Teeth Spaces Per Quadrant (Limit 4 Quadrants Per Consecutive 24 Months) ■	\$0
D4342	Periodontal Scaling and Root Planing- 1 to 3 Teeth, Per Quadrant (Limit 4 Quadrants per Consecutive 12 Months) ■	\$0
D4355	Full Mouth Debridement to Allow Evaluation and Diagnosis (1 Per Lifetime) ♦	\$0
D4910	Periodontal Maintenance (Limit of 2 Within the First 12 Months After Active Therapy) ■	\$0
Prosthetics (Removable Tooth Replacement – Dentures) Includes up to 4 adjustments within first 6 months after insertion – Replacement limit 1 every 5 years. Please note for these plans, the member's Patient Charge Schedule separates the additional \$225 for characterization; however, this charge is included in the copays listed below.		
D5110	Complete Upper Denture	\$447
D5120	Complete Lower Denture	\$447

Procedure Code ¹		PTA15
D5130	Immediate Complete Upper Denture	\$472
D5140	Immediate Complete Lower Denture	\$472
D5211	Upper Partial Denture – Resin Base (Including Clasps, Rests and Teeth)	\$417
D5212	Lower Partial Denture – Resin Base (Including Clasps, Rests and Teeth)	\$455
D5213	Upper Partial Denture – Metal (Including Clasps, Rests and Teeth)	\$485
D5214	Lower Partial Denture – Metal (Including Clasps, Rests and Teeth)	\$484
D5281	Removable Unilateral Partial Denture – One Piece Cast Metal (Including Clasps and Teeth)	\$160
D5410	Adjust Complete Denture Upper	\$0
D5411	Adjust Complete Denture Lower	\$0
D5421	Adjust Partial Denture Upper	\$0
D5422	Adjust Partial Denture Lower	\$0
Repairs to Prosthetics		
D5510	Repair Broken Complete Denture Base	\$0
D5520	Replace Missing or Broken Teeth – Complete Denture (Each Tooth)	\$0
D5610	Repair Resin Denture Base	\$0
D5620	Repair Cast Framework	\$0
D5630	Repair or Replace Broken Clasp	\$0

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Repairs to Prosthetics (continued)	
D5640 Replace Broken Teeth – Per Tooth	\$0
D5650 Add Tooth to Existing Partial Denture	\$0
D5660 Add Clasp to Existing Partial Denture	\$0
Denture Relining (Limit 1 every 36 months)	
D5710 Rebase Complete Upper Denture	\$0
D5711 Rebase Complete Lower Denture	\$0
D5720 Rebase Upper Partial Denture	\$0
D5721 Rebase Lower Partial Denture	\$0
D5730 Reline Complete Upper Denture (Chairside)	\$0
D5731 Reline Complete Lower Denture (Chairside)	\$0
D5740 Reline Upper Partial Denture (Chairside)	\$0
D5741 Reline Lower Partial Denture (Chairside)	\$0
D5750 Reline Complete Upper Denture (Laboratory)	\$0
D5751 Reline Complete Lower Denture (Laboratory)	\$0
D5760 Reline Upper Partial Denture (Laboratory)	\$0
D5761 Reline Lower Partial Denture (Laboratory)	\$0

Procedure Code ¹	PTA15
Interim Dentures (Limit 1 every 5 years)	
D5850 Tissue Conditioning, Maxillary	\$22
D5851 Tissue Conditioning, Mandibular	\$22
Oral Surgery (Includes routine postoperative treatment) Surgical removal of impacted tooth – not covered for ages below 15 unless pathology (disease) exists.	
D7111 Extraction of Coronal Remnants – Deciduous Tooth	\$0
D7140 Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	\$0
D7210 Surgical Removal of Erupted Tooth – Removal of Bone and/or Section of Tooth	\$41
D7220 Removal of Impacted Tooth – Soft Tissue	\$57
D7230 Removal of Impacted Tooth – Partially Bony	\$79
D7240 Removal of Impacted Tooth – Completely Bony	\$93
D7241 Removal of Impacted Tooth – Completely Bony, Unusual Complications	\$97
D7250 Surgical Removal of Residual Tooth Roots (Cutting Procedure)	\$41
D7280 Surgical Access of an Unerupted Tooth (<i>Excluding Wisdom Teeth</i>)	\$97
D7310 Alveoloplasty In Conjunction With Extractions – 4 or More Teeth or Tooth Spaces, Per Quadrant	\$38

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Oral Surgery (continued)					
D7311	Alveoloplasty In Conjunction With Extractions – 1 to 3 Teeth or Tooth Spaces, Per Quadrant	\$19	D8080	Comprehensive Orthodontic Treatment of the Adolescent Dentition (Banding)	\$873
D7320	Alveoloplasty Not In Conjunction With Extractions – 4 or More Teeth or Tooth Spaces, Per Quadrant	\$47	D8090	Comprehensive Orthodontic Treatment of the Adult Dentition (Banding)	\$928
D7321	Alveoloplasty Not In Conjunction With Extractions – 1 to 3 Teeth or Tooth Spaces, Per Quadrant	\$24	D8660	Pre-Orthodontic Treatment Visit	\$96
D7510	Incision and Drainage of Abscess – Intraoral Soft Tissue	\$10	D8670	Periodic Orthodontic Treatment Visit (As Part of Contract)	
D7960	Frenulectomy (Frenectomy or Frenotomy) – Separate procedure	\$72		Charge Per Month	\$53
Orthodontics (Tooth Movement) Orthodontic Treatment (Maximum benefit of 24 months of interceptive and/or comprehensive treatment. Atypical cases or cases beyond 24 months require an additional payment by the patient.)			D8210	Removable Appliance Therapy	\$250
D8010	Limited Orthodontic Treatment of the Primary Dentition	\$383	D8220	Fixed Appliance Therapy	\$262
D8020	Limited Orthodontic Treatment of the Transitional Dentition	\$482	D8680	Orthodontic Retention (Removal of Appliances, Construction and Placement of Retainer(s))	\$187
D8030	Limited Orthodontic Treatment of the Adolescent Dentition	\$683	Emergency Services		
D8040	Limited Orthodontic Treatment of the Adult Dentition	\$580	D9110	Palliative (Emergency) Treatment of Dental Pain – Minor Procedure	\$0
D8050	Interceptive Orthodontic Treatment of the Primary Dentition (Banding)	\$244	D9440	Office Visit – After Regularly Scheduled Hours	\$60
D8060	Interceptive Orthodontic Treatment of the Transitional Dentition (Banding)	\$461			
D8070	Comprehensive Orthodontic Treatment of the Transitional Dentition (Banding)	\$772			



*The term "DHMO" is used to refer to product designs that may differ by state of residence of enrollee, including but not limited to, prepaid plans, managed care plans, and plans with open access features.

¹ All CDT Codes are from *Code on Dental Procedures and Nomenclature*, a copyrighted publication provided by the American Dental Association. The American Dental Association does not endorse any codes which are not included in its current publication.

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