

IMPORTANT INFORMATION ABOUT YOUR PLAN

- This Schedule of Benefits provides a listing of procedures covered by Your Plan. For procedures that require a Copayment, the amount to be paid is shown in the column titled "Member Pays \$." You pay these Copayments to the dental office at the time of service.
- You must select a United Concordia Primary Dental Office (PDO) to receive Covered Services. Your PDO will perform the below procedures or refer You to a Specialty Care Dentist for further care. Treatment by an Out of Network Dentist is not covered, except as described in the Certificate of Coverage.
- Only procedures listed on this Schedule of Benefits are Covered Services. For services not listed (not covered), You are responsible for the full fee charged by the dentist. Procedure codes and member Copayments may be updated to meet American Dental Association (ADA) Current Dental Terminology (CDT) in accordance with national standards.
- For a complete description of Your Plan, please refer to the Certificate of Coverage and the Schedule of Exclusions and Limitations in addition to this Schedule of Benefits.
- If You have any questions about Your United Concordia Dental Plan, please call Our Customer Service Department toll free at 1-866-357-3304 or access Our Website at www.unitedconcordia.com.

ADA CODE	ADA DESCRIPTION	Member Pays \$	ADA CODE	ADA DESCRIPTION	Member Pays \$
CLINICAL ORAL EVALUATIONS			OTHER PREVENTIVE SERVICES		
D0120	Periodic oral evaluation - established patient	0	D1330	Oral hygiene instructions	0
D0140	Limited oral evaluation - problem focused	0	D1351	Sealant - per tooth	8
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0	SPACE MAINTENANCE (passive appliances)		
D0150	Comprehensive oral evaluation - new or established patient	0	D1510	Space maintainer - fixed - unilateral	42
D0160	Detailed and extensive oral evaluation - problem focused, by report	0	D1515	Space maintainer - fixed - bilateral	64
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	0	D1520	Space maintainer - removable - unilateral	55
D0180	Comprehensive periodontal evaluation - new or established patient	0	D1525	Space maintainer - removable - bilateral	72
RADIOGRAPHS/DIAGNOSTIC IMAGING (including interpretation)			D1555	Removal of fixed space maintainer	0
D0210	Intraoral - complete series (including bitewings)	0	AMALGAM RESTORATIONS (including polishing)		
D0220	Intraoral - periapical first film	0	D2140	Amalgam - one surface, primary or permanent	13
D0230	Intraoral - periapical each additional film	0	D2150	Amalgam - two surfaces, primary or permanent	17
D0240	Intraoral - occlusal film	0	D2160	Amalgam - three surfaces, primary or permanent	19
D0270	Bitewing - single film	0	D2161	Amalgam - four or more surfaces, primary or permanent	23
D0272	Bitewings - two films	0	RESIN-BASED COMPOSITE RESTORATIONS - DIRECT		
D0273	Bitewings - three films	0	D2330	Resin-based composite - one surface, anterior	15
D0274	Bitewings - four films	0	D2331	Resin-based composite - two surfaces, anterior	20
D0277	Vertical bitewings - 7 to 8 films	0	D2332	Resin-based composite - three surfaces, anterior	23
D0330	Panoramic film	0	D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	25
D0340	Cephalometric film	0	INLAY/ONLAY RESTORATIONS		
TESTS AND EXAMINATIONS			D2510	Inlay - metallic - one surface	236 ♦
D0460	Pulp vitality tests	0	D2520	Inlay - metallic - two surfaces	254 ♦
D0470	Diagnostic casts	0	D2530	Inlay - metallic - three or more surfaces	279 ♦
DENTAL PROPHYLAXIS			D2542	Onlay - metallic - two surfaces	322 ♦
D1110	Prophylaxis - adult	0	D2543	Onlay - metallic - three surfaces	342 ♦
D1120	Prophylaxis - child	0	D2544	Onlay - metallic - four or more surfaces	361 ♦
TOPICAL FLUORIDE TREATMENT (office procedure)			CROWNS - SINGLE RESTORATIONS ONLY		
D1203	Topical application of fluoride - child	0	D2710	Crown - resin-based composite (indirect)	117
D1204	Topical application of fluoride - adult	0	D2712	Crown - 3/4 resin-based composite (indirect)	128
D1206	Topical fluoride varnish; therapeutic application for moderate to high risk patients	0	D2740	Crown - porcelain/ceramic substrate	341
			D2750	Crown - porcelain fused to high noble metal	329 ♦
			D2751	Crown - porcelain fused to predominantly base metal	294
			D2752	Crown - porcelain fused to noble metal	316 ♦
			D2780	Crown - 3/4 cast high noble metal	337 ♦
			D2781	Crown - 3/4 cast predominantly base metal	337

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D2782	Crown - 3/4 cast noble metal	337◆	D3425	Apicoectomy/periradicular surgery - molar (first root)	196
D2783	Crown - 3/4 porcelain/ceramic	337	D3426	Apicoectomy/periradicular surgery (each additional root)	69
D2790	Crown - full cast high noble metal	321◆	D3450	Root amputation - per root	101
D2791	Crown - full cast predominantly base metal	293	OTHER ENDODONTIC PROCEDURES		
D2792	Crown - full cast noble metal	304◆	D3920	Hemisection (including any root removal), not including root canal therapy	84
D2794	Crown - titanium	294	D3950	Canal preparation and fitting of preformed dowel or post	0
D2799	Provisional crown	26	SURGICAL SERVICES (including usual postoperative care)		
OTHER RESTORATIVE SERVICES			D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	82
D2910	Recement inlay, onlay, or partial coverage restoration	11	D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	37
D2915	Recement cast or prefabricated post and core	11	D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	105
D2920	Recement crown	11	D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	47
D2930	Prefabricated stainless steel crown - primary tooth	30	D4245	Apically positioned flap	138
D2931	Prefabricated stainless steel crown - permanent tooth	32	D4249	Clinical crown lengthening - hard tissue	168
D2940	Sedative filling	0	D4260	Osseous surgery (including flap entry and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	205
D2950	Core buildup, including any pins	36	D4261	Osseous surgery (including flap entry and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	87
D2951	Pin retention - per tooth, in addition to restoration	12	D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	119
D2952	Post and core in addition to crown, indirectly fabricated	92	NON-SURGICAL PERIODONTAL SERVICES		
D2953	Each additional indirectly fabricated post - same tooth	50	D4341	Periodontal scaling and root planing - four or more teeth per quadrant	40
D2954	Prefabricated post and core in addition to crown	42	D4342	Periodontal scaling and root planing - one to three teeth per quadrant	17
D2957	Each additional prefabricated post - same tooth	25	D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	22
D2970	Temporary crown (fractured tooth)	84	D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, per report	100
D2971	Additional procedures to construct new crown under existing partial denture framework	25	OTHER PERIODONTAL SERVICES		
PULP CAPPING			D4910	Periodontal maintenance	32
D3110	Pulp cap - direct (excluding final restoration)	0	COMPLETE DENTURES (including routine post-delivery care)		
D3120	Pulp cap - indirect (excluding final restoration)	0	D5110	Complete denture - maxillary	343
PULPOTOMY			D5120	Complete denture - mandibular	343
D3220	Therapeutic pulpotomy (excluding final restoration)	17	D5130	Immediate denture - maxillary	359
D3221	Pulpal debridement, primary and permanent teeth	16	D5140	Immediate denture - mandibular	359
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	17	PARTIAL DENTURES (including routine post-delivery care)		
ENDODONTIC THERAPY ON PRIMARY TEETH			D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	284
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	26	D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	335
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	32	ENDODONTIC THERAPY (including treatment plan, clinical procedures and follow-up care)		
ENDODONTIC THERAPY			D3310	Endodontic therapy, anterior tooth (excluding final restoration)	75
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	75	D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	90
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	90	D3330	Endodontic therapy, molar (excluding final restoration)	178
D3330	Endodontic therapy, molar (excluding final restoration)	178	ENDODONTIC RETREATMENT		
ENDODONTIC RETREATMENT			D3346	Retreatment of previous root canal therapy - anterior	69
D3346	Retreatment of previous root canal therapy - anterior	69	D3347	Retreatment of previous root canal therapy - bicuspid	118
D3347	Retreatment of previous root canal therapy - bicuspid	118	D3348	Retreatment of previous root canal therapy - molar	284
D3348	Retreatment of previous root canal therapy - molar	284	APICOECTOMY/PERIRADICULAR SERVICES		
APICOECTOMY/PERIRADICULAR SERVICES			D3410	Apicoectomy/periradicular surgery - anterior	114
D3410	Apicoectomy/periradicular surgery - anterior	114	D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	183
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	183			

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D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	377	FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS		
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	377	D6610	Onlay - cast high noble metal, two surfaces	322◆
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	433	D6612	Onlay - cast predominantly base metal, two surfaces	322
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	433	D6614	Onlay - cast noble metal, two surfaces	322◆
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	232	FIXED PARTIAL DENTURE RETAINERS - CROWNS		
ADJUSTMENTS TO DENTURES			D6710	Crown - indirect resin based composite	295
D5410	Adjust complete denture - maxillary	10	D6740	Crown - porcelain/ceramic	295
D5411	Adjust complete denture - mandibular	10	D6750	Crown - porcelain fused to high noble metal	329◆
D5421	Adjust partial denture - maxillary	11	D6751	Crown - porcelain fused to predominantly base metal	294
D5422	Adjust partial denture - mandibular	11	D6752	Crown - porcelain fused to noble metal	316◆
REPAIRS TO COMPLETE DENTURES			D6780	Crown - 3/4 cast high noble metal	321◆
D5510	Repair broken complete denture base	19	D6781	Crown - 3/4 cast predominantly base metal	321
D5520	Replace missing or broken teeth - complete denture (each tooth)	17	D6782	Crown - 3/4 cast noble metal	321◆
REPAIRS TO PARTIAL DENTURES			D6783	Crown - 3/4 porcelain/ceramic	321
D5610	Repair resin denture base	19	D6790	Crown - full cast high noble metal	327◆
D5620	Repair cast framework	20	D6791	Crown - full cast predominantly base metal	292
D5630	Repair or replace broken clasp	23	D6792	Crown - full cast noble metal	319◆
D5640	Replace broken teeth - per tooth	17	D6794	Crown - titanium	292
D5650	Add tooth to existing partial denture	20	OTHER FIXED PARTIAL DENTURE SERVICES		
D5660	Add clasp to existing partial denture	24	D6930	Recement fixed partial denture	30
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	242	D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	44
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	242	D6972	Prefabricated post and core in addition to fixed partial denture retainer	38
DENTURE REBASE PROCEDURES			D6973	Core build up for retainer, including any pins	32
D5710	Rebase complete maxillary denture	60	D6976	Each additional indirectly fabricated post - same tooth	21
D5711	Rebase complete mandibular denture	60	D6977	Each additional prefabricated post - same tooth	11
D5720	Rebase maxillary partial denture	58	EXTRACTIONS		
D5721	Rebase mandibular partial denture	58	(includes local anesthesia, suturing, if needed, and routine postoperative care)		
DENTURE RELINE PROCEDURES			D7111	Extraction, coronal remnants - deciduous tooth	10
D5730	Reline complete maxillary denture (chairside)	36	D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	16
D5731	Reline complete mandibular denture (chairside)	36	SURGICAL EXTRACTIONS		
D5740	Reline maxillary partial denture (chairside)	33	(includes local anesthesia, suturing, if needed, and routine postoperative care)		
D5741	Reline mandibular partial denture (chairside)	33	D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	51
D5750	Reline complete maxillary denture (laboratory)	51	D7220	Removal of impacted tooth - soft tissue	72
D5751	Reline complete mandibular denture (laboratory)	51	D7230	Removal of impacted tooth - partially bony	98
D5760	Reline maxillary partial denture (laboratory)	49	D7240	Removal of impacted tooth - completely bony	113
D5761	Reline mandibular partial denture (laboratory)	48	D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	120
OTHER REMOVABLE PROSTHETIC SERVICES			D7250	Surgical removal of residual tooth roots (cutting procedure)	53
D5850	Tissue conditioning, maxillary	33	OTHER SURGICAL PROCEDURES		
D5851	Tissue conditioning, mandibular	33	D7280	Surgical access of an unerupted tooth	97
FIXED PARTIAL DENTURE PONTICS			D7283	Placement of device to facilitate eruption of impacted tooth	26
D6205	Pontic - indirect resin based composite	290	D7288	Brush biopsy - transepithelial sample collection	45
D6210	Pontic - cast high noble metal	325◆	ALVEOLOPLASTY		
D6211	Pontic - cast predominantly base metal	298	(surgical preparation of ridge for dentures)		
D6212	Pontic - cast noble metal	312◆	D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	48
D6214	Pontic - titanium	299	D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	60
D6240	Pontic - porcelain fused to high noble metal	327◆			
D6241	Pontic - porcelain fused to predominantly base metal	289			
D6242	Pontic - porcelain fused to noble metal	315◆			
D6245	Pontic - porcelain/ceramic	290			

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D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	25	FOOTNOTES		
OTHER REPAIR PROCEDURES			★	Please report under code D9999 "Unspecified adjunctive procedure, by report."	
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	89	◆	Charges for the use of precious (high noble) or semi precious (noble) metal are not included in the copayment for crowns, bridges, pontics, inlays and onlays. The decision to use these materials is a cooperative effort between the provider and the patient, based on the professional advice of the provider. Providers are expected to charge no more than an additional \$125 for these materials.	
D7963	Frenuloplasty	44			
LIMITED ORTHODONTIC TREATMENT					
D8010	Limited orthodontic treatment of the primary dentition	599			
D8020	Limited orthodontic treatment of the transitional dentition	759			
D8030	Limited orthodontic treatment of the adolescent dentition	1,071			
D8040	Limited orthodontic treatment of the adult dentition	927			
INTERCEPTIVE ORTHODONTIC TREATMENT					
D8050	Interceptive orthodontic treatment of the primary dentition	885			
D8060	Interceptive orthodontic treatment of the transitional dentition	1,309			
COMPREHENSIVE ORTHODONTIC TREATMENT					
D8070	Comprehensive orthodontic treatment of the transitional dentition	3,190			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	3,454			
D8090	Comprehensive orthodontic treatment of the adult dentition	3,540			
MINOR TREATMENT TO CONTROL HARMFUL HABITS					
D8210	Removable appliance therapy	433			
D8220	Fixed appliance therapy	537			
OTHER ORTHODONTIC SERVICES					
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	343			
UNCLASSIFIED TREATMENT					
D9110	Palliative (emergency) treatment of dental pain - minor procedure	0			
PROFESSIONAL CONSULTATION					
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	19			
PROFESSIONAL VISITS					
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	0			
MISCELLANEOUS SERVICES					
★	Broken appointment per 15 minutes (without 24-hour notice)	15			

SCHEDULE OF EXCLUSIONS AND LIMITATIONS

EXCLUSIONS

Except as specifically provided in this Certificate, Schedules of Benefits, Riders to the Certificate, no coverage will be provided for services, supplies or charges:

1. Not specifically listed in the Schedule of Benefits as a Covered Service.
2. Provided to Members by Out-of-Network Dentists except when immediate dental treatment is required as a result of a Dental Emergency occurring more than 50 miles from the Member's home.
3. Which in the opinion of the treating dentist, or the Company, are not clinically necessary, or do not have a reasonable, favorable prognosis.

This exclusion does not apply to Group Contracts and Certificates issued and delivered in Maryland.

4. That are necessary due to lack of cooperation with Primary Dental Office, or failure to comply with a professionally prescribed Treatment Plan.
5. Started or incurred prior to the Member's Effective Date of Coverage with the Company or started after the Termination Date of Coverage with the Company.
6. For consultations by a Specialty Care Dentist for services not specifically listed on the Schedule of Benefits as a Covered Service.
7. Services or supplies that are not deemed generally accepted standards of dental treatment.
8. That are the responsibility of Workers' Compensation or employer's liability insurance, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy. The Company's benefits would be in excess to the third party benefits and therefore, the Company would have right of recovery for any benefits paid in excess.

For Group Contracts and Certificates issued and delivered in Missouri and New Jersey, only services that are the responsibility of Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

For Group Contracts and Certificates issued and delivered in Texas, only services that are the responsibility of the employer's liability insurance, or for treatment of any automobile related injury shall be excluded from this Plan.

For Group Contracts and Certificates delivered in Maryland, only services related to Workers' Compensation or employer's liability insurance shall be excluded from this Plan.

For Group Contracts and Certificates issued and delivered in Florida, only services that are paid by Workers' Compensation or the employer's liability insurance, or for treatment of any automobile related injury in which the Member is entitled to payment under an automobile insurance policy shall be excluded from this Plan.

9. Services and/or appliances that alter the vertical dimension, including, but not limited to, full mouth rehabilitation, splinting, fillings to restore tooth structure lost from attrition, erosion or abrasion, appliances or any other method.

This exclusion does not apply to Group Contracts and Certificates issued in Pennsylvania if the dental condition is as a result of an accidental injury.

10. That restore tooth structure due to attrition, erosion or abrasion.
11. For periodontal splinting of teeth by any method.
12. For replacement of lost, missing, stolen or damaged prosthetic device or orthodontic appliance or for duplicate dentures, prosthetic devices or any duplicative device.
13. For replacement of existing dentures that are, or can be made serviceable.
14. For prosthetic reconstruction or other services which require a prosthodontist.
15. For assistant at surgery.
16. For elective procedures, including prophylactic extraction of third molars.
17. For congenital mouth malformations or skeletal imbalances, including, but not limited to, treatment related to cleft palate, disharmony of facial bone, or required as the result of orthognathic surgery, including orthodontic treatment, and oral and maxillofacial services, associated hospital and facility fees, anesthesia, and radiographic imaging even if the condition requiring these services involves part of the body other than the mouth or teeth. This exclusion shall not apply to newly born children of Members as defined in the definition of Dependent.

For Group Contracts and Certificates issued and delivered in Kentucky and Pennsylvania, this exclusion shall not apply to newly born children of Members as defined under the definition of Dependent including newly adoptive children, regardless of age.

For Group Contracts and Certificates issued and delivered in Indiana and New Jersey, this exclusion shall not apply to newly born children of Members as defined under the definition of Dependent.

For Group Contracts and Certificates issued and delivered in Florida, this exclusion shall not apply for diagnostic or surgical dental (not medical) procedures rendered to a Member of any age.

For Group Contracts and Certificates issued in Florida, this exclusion does not apply to diagnostic or surgical dental (not medical) procedures for treatment of TMD rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease, or injury and such procedures are covered under a Rider to the Certificate or the Schedule of Benefits.

18. For diagnostic services and treatment of jaw joint problems by any method. These jaw joint problems include but are not limited to such conditions as temporomandibular joint disorder (TMD) and craniomandibular disorders or other conditions of the joint linking the jaw bone and the complex of muscles, nerves and other tissues related to that joint.
19. For implants, surgical insertion and/or removal of, and any appliances and/or crowns attached to implants.
20. For the following, which are not included as orthodontic benefits: retreatment of orthodontic cases, changes in orthodontic treatment necessitated by patient non-cooperation, repair of orthodontic appliances, replacement of lost or stolen appliances, special appliances (including, but not limited to, headgear, orthopedic appliances, bite planes, functional appliances or palatal expanders), myofunctional therapy, cases involving orthognathic surgery, extractions for orthodontic purposes, and treatment in excess of 24 months.

For Group Contracts and Certificates issued in Florida, this exclusion does not apply to diagnostic and surgical dental (not medical) procedures for treatment of TMD rendered to a Member of any age as a result of congenital or developmental mouth malformation, disease, or injury and such procedures are covered under a Rider to the Certificate or the Schedule of Benefits.

21. For active orthodontic treatment if started prior to a Member's effective date.
22. For prescription or nonprescription drugs, home care items, vitamins or dietary supplements.
23. For hospitalization and associated costs for rendering services in a hospital.
24. For house or hospital calls for dental services.
25. For any dental or medical services performed by a physician and/or services which benefits are otherwise provided under a health care plan of the employer.
26. Which are Cosmetic in nature as determined by the Company, including, but not limited to bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.

This exclusion does not apply to Group Contracts and Certificates issued and delivered in Pennsylvania for Cosmetic services required as the result of an accidental injury.

This exclusion does not apply to Group Contracts and Certificates issued and delivered in New Jersey for Cosmetic services for newly-born children of Members as defined in the definition of Dependent.

For Group Contracts and Certificates issued and delivered in Maryland services which are Cosmetic in nature, including, bleaching, veneer facings, personalization or characterization of crowns, bridges and/or dentures.

27. For broken appointments.
28. Arising from any intentionally self-inflicted injury or contusion when the injury is a consequence of the Member's commission of or attempt to commit a felony or engagement in an illegal occupation or of the Member's being intoxicated or under the influence of illicit narcotics.

This exclusion does not apply to Group Contracts and Certificates issued and delivered in Maryland and Ohio.
29. For any condition caused by or resulting from declared or undeclared war or act thereof, or resulting from service in the national guard or in the armed forces of any country or international authority.

LIMITATIONS

The following services, if listed on the Schedule of Benefits, will be subject to limitations as set forth below:

1. Bitewing x-rays – one set(s) per six consecutive months through age 13, and one set(s) of bitewing x-rays per 12 consecutive months for age 14 and older.
2. Panoramic or full mouth x-rays – one per three-year period.
3. Prophylaxis – one per six consecutive month period.
4. Routine prophylaxis and periodontal maintenance procedures are limited to no more than any combination of one per six consecutive month period.
5. Sealants – one per tooth per three year(s) through age 15 on permanent first and second molars.
6. Fluoride treatment – one per six consecutive months through age 18.
7. Space maintainers only eligible for Members through age 18 when used to maintain space as a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop.
8. Restorations, crowns, inlays and onlays – covered only if necessary to treat diseased or fractured teeth.
9. Crowns, bridges, inlays, onlays, buildups, post and cores – one per tooth in a five-year period.
10. Crown lengthening – one per tooth per lifetime.
11. Referral for specialty care is limited to orthodontics, oral surgery, periodontics, endodontics, and pediatric dentists.

This limitation does not apply to Group Policies and Certificates issued in Maryland if the service was provided as a result of a standing or non-network referral as described in the Certificate of Coverage.
12. Coverage for referral to a pediatric Specialty Care Dentist ends on a Member's seventh birthday.
13. Pupal therapy – through age five on primary anterior teeth and through age 11 on primary posterior teeth.
14. Root canal treatment – one per tooth per lifetime.
15. Root canal retreatment – one per tooth per lifetime.
16. Periodontal scaling and root planing – one per 24 consecutive month period per area of the mouth.
17. Surgical periodontal procedures – one per 24 consecutive month period per area of the mouth.
18. Full and partial dentures – one per arch in a five-year period.
19. Denture relining, rebasing or adjustments – are included in the denture charges if provided within six months of insertion by the same dentist.
20. Subsequent denture relining or rebasing – limited to one every 36 consecutive months thereafter.
21. Oral surgery services are limited to surgical exposure of teeth, removal of teeth, preparation of the mouth for dentures, removal of tooth generated cysts up to 1.25cm, frenectomy and crown lengthening.
22. Wisdom teeth (third molars) extracted for Members under age 15 or over age 30 are not eligible for payment in the absence of specific pathology.
23. If for any reason orthodontic services are terminated or coverage under the Company is terminated before completion of the approved orthodontic treatment, the responsibility of the Company will cease with payment through the month of termination.

For Group Contracts and Certificates issued and delivered in Maryland, services will continue for 60 days after termination if paid monthly, or until the later of 60 days after termination or the end of the quarter in progress if paid quarterly. This extension of orthodontic payment does not apply if coverage was terminated due to failure to pay required Premium, fraud, or if succeeding coverage is provided by another health plan and the cost is less than or equal to the cost of coverage during the extension and there is no interruption of benefits.
24. Orthodontic treatment – not eligible for Members over age 18.
25. Comprehensive orthodontic treatment plan – one per lifetime.
26. In the case of a Dental Emergency involving pain or a condition requiring immediate treatment, the Plan covers necessary diagnostic and therapeutic dental procedures administered by an Out-of-Network Dentist up to the difference between the Out-of-Network Dentist's charge and the Member Copayment up to a maximum of \$50 for each emergency visit.

This limitation does not apply to Group Contracts and Certificates issued and delivered in California and Texas.

27. Administration of I.V. sedation or general anesthesia is limited to covered oral surgical procedures involving one or more impacted teeth (soft tissue, partial bony or complete bony impactions).
28. An Alternate Benefit Provision (ABP) may be applied by the Primary Dental Office if a dental condition can be treated by means of a professionally acceptable procedure, which is less costly than the treatment recommended by the dentist. The ABP does not commit the Member to the less costly treatment. However, if the Member and the dentist choose the more expensive treatment, the Member is responsible for the additional charges beyond those allowed for the ABP.