Something to SMILE ABOUT

A GUIDE TO YOUR DENTAL BENEFITS

Adult PPO and Pediatric Dental HMO

In the event of ambiguity, or a conflict between this summary and the Evidence of Coverage, the Evidence of Coverage shall control.

Dental benefits are underwritten by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and administered by Dominion Dental USA, Inc.
ADULT PPO DENTAL PLAN

Your dental plan emphasizes healthy smiles through prevention and the early detection of dental problems to avoid costly procedures in the future. You have the freedom to see any dentist inside or outside of the plan. You may choose to see any in-plan dentist or, if you prefer, you can visit any other licensed dentist not in the plan to receive your care. You have your choice of convenient private dental offices where you can receive care.

Your dental plan administrator and health plan carrier — Dominion Dental Services USA, Inc. (Dominion), and Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Kaiser Permanente) — are working together to help you be well, live well, and thrive.

In-plan

You receive 100 percent in-network coverage for preventive care procedures such as:

- Oral evaluation
- Routine cleanings
- Bitewing X-rays

The preventive care procedures covered in this plan account for over 65 percent of dental services most frequently performed for adults.¹

Out-of-plan

You receive 80 percent out-of-network coverage if you choose to visit a licensed dentist not included in the network of participating dentists. The dentist may charge above the amount covered by your PPO plan, and the balance is your responsibility. For a complete copayment schedule, exclusions, and limitations, please refer to your Evidence of Coverage or you can find your plan on DominionDental.com/kaiserdentists.

Choosing a dentist

In-plan dental providers

You may select any general dentist from among our network of participating dentists. When you choose an in-plan dentist, your out-of-pocket expenses are lower.

You can be confident that your in-plan dentist was carefully selected to offer quality care. All participating dentists go through a strict quality assurance program developed in accordance with the National Association of Dental Plans’ recommendations. This process confirms that each dentist has the required credentials.

For a list of participating in-plan dentists including office hours, directions, languages spoken, etc., visit DominionDental.com/kaiserdentists or call Dominion Member Services at 855-733-7524 (TTY 711), Monday through Friday, 7:30 a.m. to 6 p.m.

Out-of-plan dental providers

You can visit any licensed dentist not included in the network of participating dentists.

Deductibles and annual maximums

There is a single combined deductible for covered in-plan and out-of-plan services, per member, per plan year, of $50 ($150 family maximum). The deductible is the amount of charges that you must pay for covered dental services during a plan year before the plan begins paying its share for those services. There is also a maximum annual benefit that applies to all in-plan and out-of-plan benefits combined per member, per plan year. The annual maximum is $1,000 combined in-plan and out-of-plan.

¹Dominion Dental Services, Inc., based on annual review of utilization data, network survey and analysis report, 4th Quarter 2014.
How does the Adult PPO plan work?
On or after your effective date of coverage, you can make an appointment with any participating (in-plan) dentist. You can also choose to visit a licensed dentist not in the network of participating dentists (out-of-plan). Make sure you bring your Kaiser Permanente medical ID card to your appointment. There is no separate dental ID card.

Do I need to submit claims?
In-plan claims are submitted by the dentist. For out-of-plan claims, you may be expected to pay the dentist the full amount at the time of service and then submit a claim to Dominion Dental Services USA, Inc. You must submit the claim within 365 days of the date of service.

Claims should be mailed to:
Dominion Dental Services USA, Inc.
115 South Union Street, Suite 300
P.O. Box 1126
Elk Grove, IL 60009
Claims can be faxed to:
888-208-8290

Dedicated customer service
Quality service is an important part of any dental plan. Knowledgeable Dominion Member Services Specialists are available Monday through Friday from 7:30 a.m. to 6 p.m. to answer questions about coverage or to help you find a participating dentist. Dominion’s interactive voice response system is available 24 hours a day for information about participating dental providers in your area or to help you select a dental provider. The most up-to-date list of participating dental providers can be found online.

Toll free phone: 855-733-7524; TTY 711
Fax: 855-485-0115
Mailing address:
Dominion Dental Services USA, Inc.
115 South Union Street, Suite 300
Alexandria, VA 22314
Web: DominionDental.com/kaiserdentists

Make changes online
Dominion provides members with secure online access to:
• Plan information
• Dentist search and dental office transfers
• Contact information
• Member services requests and general correspondence

All changes are confirmed by return email.
## Adult PPO Dental Coverage Schedule

### 100/80/50/0

<table>
<thead>
<tr>
<th>Benefit Coverage</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Class I</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Class II</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Class III</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Class IV</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Endo/Perio</td>
<td>Class III Benefits</td>
<td>Class III Benefits</td>
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</table>

### Annual Deductible

<table>
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<tr>
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<th>In-Network</th>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td>Amount</td>
<td>$50</td>
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<tr>
<td>Max per Adults</td>
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<td>$150</td>
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<tr>
<td>Applies to all benefits</td>
<td>No. Waived on Class I Benefits</td>
<td>No. Waived on Class I Benefits</td>
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### Maximums

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
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</thead>
<tbody>
<tr>
<td>Amount</td>
<td>$1,000</td>
<td>$1,000</td>
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<tr>
<td>Lifetime Ortho</td>
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</table>

*Annual Maximum applies to Class I, Class II, and Class III Benefits.

### Waiting Periods

<table>
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<tr>
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<th>In-Network</th>
<th>Out-of-Network</th>
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<tbody>
<tr>
<td>Class I</td>
<td>NONE</td>
<td>NONE</td>
</tr>
<tr>
<td>Class II</td>
<td>NONE</td>
<td>NONE</td>
</tr>
<tr>
<td>Class III</td>
<td>12 Months</td>
<td>12 Months</td>
</tr>
<tr>
<td>Class IV</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

- Deductible is combined for all services for each plan year per member – maximum $150 for adults.
- Annual maximum amount listed is a combined total that applies to both in and out-of-network services.
- Services may be received from any licensed dentist.
- If course of treatment is to exceed $300, prior review is requested.

Plan will pay either the participating dentist's negotiated copayment or the maximum allowable charge (subject to benefit coverage percentage) for dental procedures and services as shown below, after any required annual deductible.
Additional benefit information

Plan will pay negotiated copayments or maximum allowable charges for in-plan dentists after any required annual deductible. Plan will also pay maximum allowable charges for out-of-plan dentists after any required annual deductible. Please see below for covered procedures and services:

Class I. Diagnostic and preventive services:
1. Two evaluations per plan year including a maximum of one comprehensive evaluation per 36 months
2. One emergency or problem focused exam (D0140) per plan year
3. Two prophylaxis (cleaning, scaling, and polishing teeth) per calendar year (one additional cleaning is covered during pregnancy and for diabetic patients)
4. Bitewing X-rays, 2 per plan year
5. Periapical X-rays
6. Emergency palliative treatment (only if no services other than exam and X-rays were performed on the same date of service)

Class II. Basic services:
1. Simple extraction of teeth
2. Amalgam and composite fillings excluding posterior composite fillings (restorations of mesiolingual, distolingual, mesiobuccal, and distobuccal surfaces considered single surface restorations), per tooth, per surface every 24 months
3. Pin retention of fillings (multiple pins on the same tooth are allowable as one pin)
4. Antibiotic injections administered by a dentist
5. One diagnostic X-ray, full or panoramic per 60 months

Class III. Major services:
1. Oral surgery, including postoperative care for:
   a. Removal of teeth, including impacted teeth
   b. Extraction of tooth root
   c. Alveolectomy, alveoplasty, and frenectomy
   d. Excision of periocoronal gingiva, exostosis, or hyper plastic tissue, and excision of oral tissue for biopsy
   e. Reimplantation or transplantation of a natural tooth
   f. Excision of a tumor or cyst and incision and drainage of an abscess or cyst
2. Endodontic treatment of disease of the tooth, pulp, root, and related tissue, limited to:
   a. Root canal therapy (not covered if pulp chamber was opened before effective date of coverage)
   b. Pulpotomy
   c. Apicoectomy
   d. Retrograde fillings, per root per lifetime
3. Periodontic services, limited to:
   a. Two periodontal cleanings following surgery per plan year (D4341 is not considered surgery)
   b. One root scaling and planing per quadrant of mouth per 24 months
   c. Occlusal adjustment performed with covered surgery
   d. Gingivectomy and gingival curettage
   e. Osseous surgery including flap entry and closure
   f. One pedicle or free soft tissue graft per site per lifetime
   g. One appliance (night guards) per 5 years within 6 months of osseous surgery
   h. One full mouth debridement per lifetime
Class III. Major services, continued:

4. One study model per 36 months

5. Crown build-up for non-vital teeth

6. Recementing bridges, inlays, onlays and crowns after first 12 months and per 12 months per tooth thereafter

7. One repair of dentures or fixed bridgework per 24 months

8. General anesthesia and analgesic, including intravenous sedation, in conjunction with covered oral surgery, periodontal surgery

9. Restoration services, limited to:
   a. Gold or porcelain inlays, onlays, and crowns for tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling
   b. Replacement of existing inlay, onlay, or crown, after 7 years of the restoration initially placed or last replaced (will not apply if replacement is necessary due to the extraction of functioning natural teeth after the effective date of coverage)
   c. Post and core in addition to crown when separate from crown for endodontically treated teeth, with a good prognosis endodontically and periodontally

10. Prosthetic services, limited to:
    a. Initial placement of dentures or fixed bridgework (including acid etch metal bridges)
    b. Replacement of dentures or fixed bridgework that cannot be repaired after 7 years from the date of last placement
    c. Addition of teeth to existing partial denture
    d. One relining or rebasing of existing removable dentures per 24 months (only after 24 months from date of last placement, unless an immediate prosthesis replacing at least 3 teeth)

Class IV. Orthodontia services: Not covered
Diagnostic, active, and retention treatment to include removable fixed appliance therapy and comprehensive therapy.
EXCLUSIONS AND LIMITATIONS

Exclusions
The following services are not covered:

1. Services which are covered under worker’s compensation or employer’s liability laws.
2. Services which are not necessary for the patient’s dental health.
3. Reconstructive, plastic, cosmetic, elective or aesthetic dentistry.
4. Oral surgery requiring the setting of fractures and dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where such services should not be performed in a dental office.
6. Dispensing of drugs.
8. Treatment required for conditions resulting while on active duty as a member of the armed forces of any nation or from war or acts of war, whether declared or undeclared.
9. Implant removal or the replacement of dentures, bridges, inlays or crowns that can be repaired or restored to normal function.
10. Diagnosis or treatment of Temporomandibular Disorder (TMD) syndromes, problems and/or occlusal disharmony.
11. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth.
12. Services not listed as covered.
13. Implants; replacement of lost, stolen or damaged prosthetic or orthodontic appliances; athletic mouthguards; precision or semi-precision attachments; denture duplication; sealants; periodontal splinting of teeth.
14. Services for increasing vertical dimension, replacing tooth structure lost by attrition, and correcting developmental malformations and/or congenital conditions.
15. Procedures that in the opinion of the plan are experimental or investigative in nature because they do not meet professionally recognized standards of dental practice and/or have not been shown to be consistently effective for the diagnosis or treatment of the member’s condition.
16. Treatment of cleft palate, malignancies or neoplasms.
17. Any service or supply rendered to replace a tooth lost prior to the effective date of coverage. This exclusion expires after 36 months of member’s continuous coverage under the plan.
18. MARYLAND POLICYHOLDERS ONLY: Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines was provided as a result of a prohibited referral. “Prohibited referral” means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.

Limitations
Covered dental services are subject to the following limitations:

1. Periodic oral exams, prophylaxes (cleaning, scaling and polishing teeth) and bitewing X-rays are limited to twice per contract year. One additional cleaning is covered during pregnancy and for diabetic patients.
2. Comprehensive evaluations are limited to once per 36 months; emergency or problem focused exams (D0140) are limited to once per contract year.
3. Emergency palliative treatment is covered if no services other than an exam and X-rays were performed on the same date of service.
4. Amalgam and composite fillings excluding posterior composite fillings are limited to once per tooth per surface every 24 months.
5. Diagnostic X-rays, full or panoramic, are limited to once per 60 months.
6. Root canal therapy is not covered if pulp chamber was opened before effective date of coverage.
7. Retrograde fillings are limited to once per root per lifetime.
8. Periodontal cleanings following surgery are limited to twice per contract year.
9. Root planing or scaling is limited to once per quadrant every 24 months.
10. Pedicle or free soft tissue graft is limited to once per site per lifetime.
11. Appliance (night guard) is limited to one per 5 years within 6 months of osseous surgery.
12. Full mouth debridement is limited to once per lifetime.
13. Study model is limited to one per 36 months.
14. Recementing bridges, inlays, onlays and crowns is limited to once per tooth per 12 months after the first 12 months.
15. Repair of dentures or fixed bridgework is limited to once per 24 months. Replacement of dentures or fixed bridgework that cannot be repaired is covered after 7 years from the date of last placement.
16. Gold or porcelain inlays, onlays and crowns are covered only for a tooth with extensive caries or fracture that is unable to be restored with an amalgam or composite filling.
17. Replacement of existing inlay, onlay, or crown is covered after 7 years of the restoration initially placed or last replaced (will not apply if replacement is necessary due to the extraction of functioning natural teeth after the effective date of coverage).
18. Relining or rebasing of existing removable dentures is covered once per 24 months only after 24 months from the date of last placement, unless an immediate prosthesis replacing at least 3 teeth.
Your medical plan includes pediatric dental benefits for children up to age 19. The pediatric dental plan emphasizes healthy smiles through prevention and the early detection of dental problems to avoid costly procedures in the future. The combination of predictable costs and no deductibles helps children reach a state of good oral health without facing the high cost of treatment typical of many dental plans. Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., and Dominion Dental Services USA, Inc. (Dominion), are working together to help you be well, live well, and thrive.

The Pediatric Dental HMO plan provides coverage for more than 250 dental procedures through one of the largest networks in the Mid-Atlantic area. You pay a $10 copay for office visits, and a $0 copay for preventive care procedures such as:

- Oral evaluation
- Routine cleanings
- Certain X-ray procedures
- Topical fluoride

The preventive care procedures covered on this plan account for almost 90 percent of the most frequently performed services for children. Other covered dental services are provided at a reduced copayment.

Save on restorative care

More extensive care (fillings, crowns, dentures, root canals, periodontal treatment, oral surgery, etc.) is provided at copayments lower than the usual and customary charges for these services. When covered, specialty care is covered at the listed copayment whether performed by a participating general dentist or participating specialist. For a complete copayment schedule, exclusions, and limitations, please refer to your Evidence of Coverage or you can find your plan on DominionDental.com/kaiserdentists.

Choosing a dentist

In order to use your pediatric dental benefits, you must select a Dominion dentist for your child’s care. Each eligible family member may use a different participating dentist. To select a participating dentist or for information about a dentist including office hours, directions, languages spoken, etc., visit DominionDental.com/kaiserdentists or call Dominion Member Services at 855-733-7524 (TTY 711), Monday through Friday, 7:30 a.m. to 6 p.m. Specialty care is also available in many locations. To receive treatment from a participating specialist, ask your participating general dentist to arrange a referral. Services received from nonparticipating dentists are not covered.

Quality dental care

You can be confident that your child’s dentist was carefully selected to offer quality care. All participating dentists go through a strict quality assurance program developed in accordance with the National Association of Dental Plans’ recommendations. This process confirms that each dentist has the required credentials and has passed a thorough on-site office evaluation.

Out-of-pocket maximum

Please refer to your Evidence of Coverage for your out-of-pocket maximum.
How does the preventive plan work?
After your effective date of coverage, you can make an appointment with your chosen participating general dentist. Make sure you bring your Kaiser Permanente medical ID card to your appointment. There is no separate dental ID card. There is virtually no paperwork and no pre-existing condition exclusions to worry about.

Dedicated customer service
Quality customer service is an important part of any dental plan. Knowledgeable Dominion Member Services Specialists are available Monday through Friday from 7:30 a.m. to 6 p.m. to answer questions about coverage or to help you find a participating dentist. Dominion’s interactive voice response system is available 24 hours a day for information about participating dental providers in your area or to help you select a dental provider. The most up-to-date list of participating dental providers can be found online.

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Fax: 855-485-0115
Mailing address:
Dominion Dental Services USA, Inc.
115 South Union Street, Suite 300
Alexandria, VA 22314
Web: DominionDental.com/kaiserdentists
Description of benefits & member copayments for pediatric services (up to age 19)

Annual Out-of-Pocket Maximum: Please refer to your medical plan for specific details.

Procedures not shown in this list are not covered. Refer to the Evidence of Coverage for a complete description of the terms and conditions of your covered dental benefit.

Copayments quoted in the “Member Copayment” column apply only when performed by a participating general dentist or dental specialist. If specialty care is required, your general dentist must refer you to a participating specialist except as otherwise described in the Evidence of Coverage.

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<th>ADA CODE</th>
<th>BENEFIT</th>
<th>MEMBER COPAYMENT</th>
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</thead>
<tbody>
<tr>
<td>D9439</td>
<td>Office visit</td>
<td>$10</td>
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<tr>
<td>D0120</td>
<td>Periodic oral evaluation – established patient</td>
<td>$0</td>
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<td>D0140</td>
<td>Limited oral evaluation – problem focused</td>
<td>$0</td>
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<td>D0145</td>
<td>Oral evaluation for a patient under 3 years of age</td>
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<td>D0150</td>
<td>Comprehensive oral evaluation – new or established patient</td>
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<tr>
<td>D0160</td>
<td>Detailed and extensive oral eval – problem focused</td>
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<td>D0170</td>
<td>Re-evaluation – limited, problem focused</td>
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<tr>
<td>D0210</td>
<td>Intraoral – complete series (including bitewings)</td>
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<tr>
<td>D0220/30</td>
<td>Intraoral – periapical first film</td>
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<td>D0240</td>
<td>Intraoral – occlusal film</td>
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<td>D0250/60</td>
<td>Extraoral – first film and each additional film</td>
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<td>D0270-74</td>
<td>Bitewing X-rays – 1 to 4 films</td>
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<td>D0277</td>
<td>Vertical bitewings – 7 to 8 films</td>
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<td>D0290</td>
<td>Posterior/anterior or lateral skull bone film</td>
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<td>D0310</td>
<td>Sialography</td>
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<td>Do320</td>
<td>Temporomandibular joint arthrogram, including injection</td>
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<td>D0321</td>
<td>Other temporomandibular joint films, by report</td>
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<td>D0330</td>
<td>Panoramic film</td>
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<td>D0350</td>
<td>Oral/facial photographic images</td>
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<td>D0460</td>
<td>Pulp vitality tests</td>
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<td>D0470</td>
<td>Diagnostic casts</td>
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<td>D0486</td>
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<td>D1120</td>
<td>Prophylaxis (cleaning) – child</td>
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<td>D1203</td>
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<td>D1206</td>
<td>Topical fluoride varnish for mod/high risk caries patients</td>
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<td>D1208</td>
<td>Topical application of fluoride</td>
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<td>Nutritional counseling for control of dental disease</td>
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<td>Oral hygiene instructions</td>
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<td>D1351</td>
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<td>Prev resin rest. mod/high caries risk – permanent tooth</td>
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<td><strong>SPACE MAINTainers</strong></td>
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<td>D1510/20</td>
<td>Space maintainer – fixed/removable – unilateral</td>
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<td>D1515/25</td>
<td>Space maintainer – fixed/removable – bilateral</td>
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<td>D1550</td>
<td>Re-cementation of space maintainer</td>
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<td>D1555</td>
<td>Removal of fixed space maintainer, by non-originating dentist</td>
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<td><strong>RESTORATIVE DENTISTRY (FILLINGS)</strong></td>
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<tr>
<td>D2140</td>
<td>Amalgam – 1 surface</td>
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<td>D2150</td>
<td>Amalgam – 2 surfaces</td>
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<tr>
<td>D2160</td>
<td>Amalgam – 3 surfaces</td>
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<tr>
<td>D2161</td>
<td>Amalgam – 4 or more surfaces, prim. or perm.</td>
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## Pediatric Dental HMO Plan

<table>
<thead>
<tr>
<th>ADA CODE</th>
<th>BENEFIT</th>
<th>MEMBER COPAYMENT</th>
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<td>RESIN/COMPOSITE RESTORATIONS (TOOTH COLORED)</td>
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<td>D2330</td>
<td>Resin-based composite – 1 surface, anterior</td>
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<td>D2331</td>
<td>Resin-based composite – 2 surfaces, anterior</td>
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<td>D2332</td>
<td>Resin-based composite – 3 surfaces, anterior</td>
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<td>D2335</td>
<td>Resin-based composite – 4 or more surfaces, anterior</td>
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<td>D2390</td>
<td>Resin-based composite crown, anterior</td>
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<td>Resin-based composite – 1 surface, posterior</td>
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<td>Resin-based composite – 2 surfaces, posterior</td>
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<td>Resin-based composite – 3 surfaces, posterior</td>
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<td>Sedative filling</td>
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<td>Core buildup, including any pins</td>
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<td>Pin retention – per tooth, in addition to restoration</td>
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<td>Pulp cap – direct/indirect (excl. final restoration)</td>
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<td>CROWNS &amp; BRIDGES*</td>
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<td>D2644</td>
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*All copayments exclude the cost of noble and precious metals. An additional copayment will be charged if these materials are used.
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<td>Crown – porcelain fused metal</td>
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<td>Crown – 3/4 cast with metal</td>
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<td>Crown – 3/4 porcelain/ceramic</td>
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<td>Crown – full cast metal</td>
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<td>Recement inlay, onlay/crown or partial coverage rest.</td>
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<td>Prefabricated stainless steel crown – permanent tooth</td>
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<td>Prefabricated stainless steel crown w/resin window</td>
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<td>Prefabricated esthetic coated primary tooth</td>
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<td>Post removal (not in conjunction with endo. therapy)</td>
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<td>Removable unilateral partial denture – one piece cast metal</td>
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<td>Adjust complete denture – maxillary/mandibular</td>
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<td>Repair broken denture base – complete/resin</td>
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<td>Replace missing or broken teeth – complete denture</td>
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<td>Clasp repaired, replaced or added</td>
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<td>Replace broken teeth – per tooth</td>
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<td>Add tooth to existing partial denture</td>
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<td>Replace all teeth and acrylic on cast metal framework</td>
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<td>Rebase complete maxillary/mandibular denture</td>
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<td>Reline complete maxillary/mandibular denture (chairside)</td>
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<td>Tissue conditioning – maxillary/mandibular</td>
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<td>Cleaning and maintenance prosthetic appliance</td>
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<td>Implant porcelain/metal crown</td>
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<td>Pontic – porcelain fused metal</td>
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<td>Retainer – cast metal for resin bonded fixed prosthesis</td>
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<td>Inlay – cast predominantly base metal, 2 surfaces</td>
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<td>Crown – resin with metal</td>
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*All copayments exclude the cost of noble and precious metals. An additional copayment will be charged if these materials are used.
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<tbody>
<tr>
<td>D6740</td>
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<td>D6780</td>
<td>Crown – 3/4 cast high noble metal</td>
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<td>Crown – 3/4 cast predominantly base metal</td>
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<td>Crown – 3/4 porcelain/ceramic</td>
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<td>Recement fixed partial denture</td>
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<td>Post and core in addition to fixed part. dent. ret.</td>
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<td>Core build up for retainer, including any pins</td>
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<td>Coping – metal</td>
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<td>D6976</td>
<td>Each additional indirectly fabricated post – same tooth</td>
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<td>Each additional prefabricated post – same tooth</td>
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<td>Fixed partial denture repair, by report</td>
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**ADJUNCTIVE GENERAL SERVICES**

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<td>Regional block anesthesia</td>
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<td>Deep sedation/general anesthesia – each add. 15 min.</td>
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<td>Analgesia, anxiolysis, inhalation of nitrous oxide</td>
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<td>Intravenous (IV) conscious sedation/analgesia – first 30 min.</td>
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<td>Non-intravenous conscious sedation</td>
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<td>Consultation (diagnostic service by nontreating dentist)</td>
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<td>Fabrication of athletic mouthguard</td>
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<td>Occlusion analysis – mounted case</td>
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<td>Occlusal adjustment – limited</td>
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<td>Pulpal debridement, primary and permanent teeth</td>
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<td>Incomp endo. Therapy-inop. or fractured tooth</td>
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<td>D3421</td>
<td>Apicoectomy/periradicular surgery, bicuspid (first root)</td>
<td>$364</td>
</tr>
<tr>
<td>D3425</td>
<td>Apicoectomy/periradicular surgery, molar (first root)</td>
<td>$418</td>
</tr>
<tr>
<td>ADA CODE</td>
<td>BENEFIT</td>
<td>MEMBER COPAYMENT</td>
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<tr>
<td>----------</td>
<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>D3426</td>
<td>Apicoectomy/periradicular surgery, (each additional root)</td>
<td>$152</td>
</tr>
<tr>
<td>D3427</td>
<td>Periradicular surgery w/o apicoectomy</td>
<td>$266</td>
</tr>
<tr>
<td>D3428</td>
<td>Bone graft in conj. w/periradicular surgery, per tooth, single site</td>
<td>$743</td>
</tr>
<tr>
<td>D3429</td>
<td>Bone graft in conj. w/periradicular surgery, additional contiguous tooth, same site</td>
<td>$582</td>
</tr>
<tr>
<td>D3430</td>
<td>Retrograde filling – per root</td>
<td>$119</td>
</tr>
<tr>
<td>D3431</td>
<td>Biologic materials to aid soft/osseous tissue regen in conjunction w/ periradicular surgery</td>
<td>$407</td>
</tr>
<tr>
<td>D3432</td>
<td>Guided tissue regen, resorbable barrier, per site, in conjunction w/ periradicular surgery</td>
<td>$815</td>
</tr>
<tr>
<td>D3450</td>
<td>Root amputation – per root</td>
<td>$234</td>
</tr>
<tr>
<td>D3470</td>
<td>Intentional reimplantation</td>
<td>$718</td>
</tr>
<tr>
<td>D3920</td>
<td>Hemisection, not inclusing root canal therapy</td>
<td>$234</td>
</tr>
<tr>
<td>D3950</td>
<td>Canal prep/fitting of preformed dowel or post</td>
<td>$136</td>
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**PERIODONTICS**

<table>
<thead>
<tr>
<th>ADA CODE</th>
<th>BENEFIT</th>
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<tbody>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation – new or established patient</td>
<td>$0</td>
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<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty – 4 or more contiguous teeth, per quadrant</td>
<td>$279</td>
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<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty – 1 to 3 teeth, per quadrant</td>
<td>$100</td>
</tr>
<tr>
<td>D4230</td>
<td>Anatomical crown exposure, 4 or more teeth per quadrant</td>
<td>$454</td>
</tr>
<tr>
<td>D4231</td>
<td>Anatomical crown exposure, 1 to 3 teeth per quadrant</td>
<td>$424</td>
</tr>
<tr>
<td>D4240</td>
<td>Gingival flap procedure, including root planing – 4 or more contiguous teeth per quadrant</td>
<td>$345</td>
</tr>
<tr>
<td>D4241</td>
<td>Gingival flap procedure, including root planing – 1 to 3 teeth, per quadrant</td>
<td>$106</td>
</tr>
<tr>
<td>D4249</td>
<td>Clinical crown lengthening – hard tissue</td>
<td>$576</td>
</tr>
<tr>
<td>D4260</td>
<td>Osseous surgery – 4 or more teeth, per quadrant</td>
<td>$499</td>
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<tr>
<td>D4261</td>
<td>Osseous surgery – 1 to 3 teeth, per quadrant</td>
<td>$392</td>
</tr>
<tr>
<td>D4268</td>
<td>Surgical revision procedure, per tooth</td>
<td>$358</td>
</tr>
<tr>
<td>D4274</td>
<td>Distal or proximal wedge procedure</td>
<td>$308</td>
</tr>
<tr>
<td>D4320</td>
<td>Provisional splinting – intracoronal</td>
<td>$427</td>
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<tr>
<td>D4321</td>
<td>Provisional splinting – extracoronal</td>
<td>$377</td>
</tr>
<tr>
<td>D4341</td>
<td>Perio scaling and root planing – 4 or more contiguous teeth, per quadrant</td>
<td>$109</td>
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<tr>
<td>D4342</td>
<td>Perio scaling and root planing – 1 to 3 teeth, per quadrant</td>
<td>$63</td>
</tr>
<tr>
<td>D4355</td>
<td>Full mouth debridement</td>
<td>$89</td>
</tr>
<tr>
<td>D4381</td>
<td>Localized delivery of chemotherapeutic agents</td>
<td>$98</td>
</tr>
<tr>
<td>D4910</td>
<td>Periodontal maintenance</td>
<td>$74</td>
</tr>
<tr>
<td>D4920</td>
<td>Unscheduled dressing change by non-treating dentist</td>
<td>$84</td>
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<tr>
<td></td>
<td><strong>ORAL SURGERY</strong></td>
<td></td>
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<tr>
<td>D7111</td>
<td>Extraction, coronal remnants – deciduous tooth</td>
<td>$56</td>
</tr>
<tr>
<td>D7140</td>
<td>Extraction, erupted tooth or exposed root</td>
<td>$69</td>
</tr>
<tr>
<td>D7210</td>
<td>Surgical removal of erupted tooth requiring bone cut</td>
<td>$133</td>
</tr>
<tr>
<td>D7220</td>
<td>Removal of impacted tooth – soft tissue</td>
<td>$151</td>
</tr>
<tr>
<td>D7230</td>
<td>Removal of impacted tooth – partially bony</td>
<td>$196</td>
</tr>
<tr>
<td>D7240</td>
<td>Removal of impacted tooth – completely bony</td>
<td>$241</td>
</tr>
<tr>
<td>D7241</td>
<td>Removal of impacted tooth – completely bony with unusual surgical complications</td>
<td>$217</td>
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<tr>
<td>D7250</td>
<td>Surgical removal of residual tooth roots</td>
<td>$141</td>
</tr>
<tr>
<td>D7251</td>
<td>Coronectomy-intentional partial tooth removal</td>
<td>$141</td>
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<tr>
<td>D7260</td>
<td>Oroantral fistula closure</td>
<td>$578</td>
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<tr>
<td>D7270</td>
<td>Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
<td>$226</td>
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<tr>
<td>D7272</td>
<td>Tooth transplantation</td>
<td>$615</td>
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<tr>
<td>D7280</td>
<td>Surgical access of an unerupted tooth</td>
<td>$153</td>
</tr>
<tr>
<td>D7285</td>
<td>Biopsy of oral tissue – hard (bone, tooth)</td>
<td>$387</td>
</tr>
<tr>
<td>D7286</td>
<td>Biopsy of oral tissue – soft (all others)</td>
<td>$295</td>
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<tr>
<td>D7290</td>
<td>Surgical repositioning of teeth</td>
<td>$407</td>
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<tr>
<td>D7291</td>
<td>Transseptal fiberotomy/ supra crestal fiberotomy, by report</td>
<td>$60</td>
</tr>
<tr>
<td>D7310/20</td>
<td>Alveoloplasty, per quadrant</td>
<td>$141</td>
</tr>
<tr>
<td>D7311/21</td>
<td>Alveoloplasty in conjunction with/out extractions</td>
<td>$141</td>
</tr>
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<tr>
<td>D7340</td>
<td>Vestibuloplasty – ridge ext. sec. epithel.</td>
<td>$923</td>
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<tr>
<td>D7350</td>
<td>Vestibuloplasty – ridge ext. inc. grafts, etc</td>
<td>$1,776</td>
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<tr>
<td>D7410</td>
<td>Excision of benign lesion up to 1.25 cm</td>
<td>$278</td>
</tr>
<tr>
<td>D7440</td>
<td>Excision of malignant tumor – lesion diam. &lt;=1.25cm</td>
<td>$608</td>
</tr>
<tr>
<td>D7450</td>
<td>Removal of benign odon cyst/tumor – diam. &lt;=1.25cm</td>
<td>$354</td>
</tr>
<tr>
<td>D7451</td>
<td>Removal of benign odon cyst/tumor – diam. &gt;1.25cm</td>
<td>$543</td>
</tr>
<tr>
<td>D7460</td>
<td>Removal of benign nonodon cyst/tumor – diam. &lt;=1.25cm</td>
<td>$516</td>
</tr>
<tr>
<td>D7461</td>
<td>Removal of benign nonodon cyst/tumor – diam. &gt;1.25cm</td>
<td>$718</td>
</tr>
<tr>
<td>D7471</td>
<td>Removal of lateral exostosis</td>
<td>$351</td>
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<tr>
<td>D7472/73</td>
<td>Removal of torus palatinus/mandibularis</td>
<td>$480</td>
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<tr>
<td>D7510</td>
<td>Incision and drainage of abscess – intraoral soft tissue</td>
<td>$96</td>
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<tr>
<td>D7520</td>
<td>Incision and drainage of abscess – extra. soft tissue</td>
<td>$116</td>
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<tr>
<td>D7550</td>
<td>Partial ostect/sequestrect non-vital bone rem.</td>
<td>$336</td>
</tr>
<tr>
<td>D7960</td>
<td>Frenulectomy (frenectomy or frenotomy) – separate procedure</td>
<td>$263</td>
</tr>
<tr>
<td>D7970</td>
<td>Excision of hyperplastic tissue – per arch</td>
<td>$233</td>
</tr>
<tr>
<td>D7971</td>
<td>Excision of pericoronal gingiva</td>
<td>$131</td>
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**ORTHODONTICS – PRE-AUTHORIZATION REQUIRED**

<table>
<thead>
<tr>
<th>ADA CODE</th>
<th>BENEFIT</th>
<th>MEMBER COPAYMENT</th>
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<tbody>
<tr>
<td>D8070</td>
<td>Comprehensive orthodontic treatment – transitional dentition</td>
<td>$3,304</td>
</tr>
<tr>
<td>D8080</td>
<td>Comprehensive orthodontic treatment – adolescent dentition</td>
<td>$3,422</td>
</tr>
<tr>
<td>D8090</td>
<td>Comprehensive orthodontic treatment – adult dentition</td>
<td>$3,658</td>
</tr>
<tr>
<td>D8660</td>
<td>Pre-orthodontic treatment visit</td>
<td>$413</td>
</tr>
<tr>
<td>D8670</td>
<td>Periodic ortho. treatment visit (as part of contract)</td>
<td>$118</td>
</tr>
<tr>
<td>D8680</td>
<td>Orthodontic retention (rem. of appl. and placement of retainer(s))</td>
<td>$413</td>
</tr>
<tr>
<td>D8692</td>
<td>Replacement of lost or broken retainer</td>
<td>$179</td>
</tr>
<tr>
<td>D8693</td>
<td>Rebonding or recementing fixed dentures</td>
<td>$174</td>
</tr>
<tr>
<td>D8694</td>
<td>Repair of fixed retainers, includes reattachment</td>
<td>$174</td>
</tr>
</tbody>
</table>
MARYLAND PEDIATRIC DENTAL HMO EXCLUSIONS AND LIMITATIONS

Exclusions
The following services are not covered:

1. Services which are covered under worker’s compensation or employer’s liability laws.
2. Services which are not necessary for the patient’s dental health as determined by the plan.
3. Cosmetic, elective or aesthetic dentistry except as required due to accidental bodily injury to sound natural teeth as determined by the plan.
4. Oral surgery requiring the setting of fractures or dislocations.
5. Services with respect to malignancies, cysts or neoplasms, hereditary, congenital, mandibular prognathism or development malformations where, in the opinion of the plan, such services should not be performed in a dental office.
6. Dispensing of drugs.
8. Replacement due to loss or theft of prosthetic appliance.
9. Procedures not listed as covered benefits under this plan.
10. Services obtained outside of the dental office in which enrolled and that are not preauthorized by such office or the health plan or dental administrator as described in the Evidence of Coverage (except for Continuity of Care for new members and dental emergencies as described in the Evidence of Coverage).
11. Services performed by a participating specialist without a referral from a participating general dentist (with the exception of orthodontics). A referral form is required. Participating dentists should refer to specialty care referral guidelines.
12. Elective surgery including, but not limited to, extraction of non-pathologic, asymptomatic impacted teeth as determined by the plan. The prophylactic removal of these teeth may be covered subject to review.
13. Any bill, or demand for payment, for a dental service that the appropriate regulatory board determines was provided as a result of a prohibited referral. “Prohibited referral” means a referral prohibited by Section 1-302 of the Maryland Health Occupations Article.
14. Non-medically necessary orthodontia and Phase I Treatment for medically necessary orthodontia are not covered benefits under this policy. The provider agreements create no liability for payment by the plan, and payments by the member for these services do not contribute to the out-of-pocket maximum. The Invisalign system and similar specialized braces are not a covered benefit.

Limitations
Covered dental services are subject to the following limitations:

1. One (1) evaluation (D0120, D0145, D0150, D0160) is covered two (2) times per calendar year, per patient.
2. One (1) teeth cleaning (D1110 or D1120) is covered two (2) times per calendar year, per patient.
3. One (1) topical fluoride application (D1203, D1204 or 1208) is covered two (2) times per calendar year, per patient; four (4) fluoride varnish treatments are covered per calendar year, per patient; children age three (3) and above; eight (8) topical fluoride varnishes are covered per calendar year, per patient up to age two (2).
4. Two (2) bitewing X-rays are covered per calendar year, per patient.
5. One (1) set of full mouth X-rays or panoramic film is covered every three (3) years. Panoramic X-rays are limited to ages six (6) and above. No more than one (1) set of X-rays are covered per provider/location.
6. One (1) sealant per tooth is covered per lifetime, per patient (limited to occlusal surfaces of posterior permanent teeth without restorations or decay).
7. One (1) space maintainer (D1510, D1520, D1515 or D1525) is covered per 24 months, per patient, per arch.
8. Replacement of a filling is covered if it is more than three (3) years from the date of original placement.
9. Replacement of a crown or denture is covered if it is more than five (5) years from the date of original placement.
10. Replacement of a prefabricated resin and stainless steel crown (D2930, D2932, D2933, D2934) is covered if it is more than three (3) years from the date of original placement, per tooth, per patient.
11. Crown and bridge copayments apply to treatment involving five (5) or fewer units when presented in a single treatment plan.
12. Relining and rebasing of dentures is covered once per 24 months, per patient, only after six (6) months of initial placement.
13. Root canal treatment and retreatment of previous root canal are covered once per lifetime, per tooth.
14. Periodontal scaling and root planing (D4341 or D4342), osseous surgery (D4260 or D4261) and gingivectomy or gingivoplasty (D4210 or D4211) are limited to one (1) per 24 months, per patient, per quadrant.
15. Full mouth debridement is covered once per 24 months, per patient.
16. Procedure code D4381 is limited to one (1) benefit per tooth for three teeth per quadrant; or a total of 12 teeth for all four (4) quadrants per 12 months. Must have pocket depths of five (5) millimeters or greater.
17. Periodontal surgery of any type, including any associated material, is covered once every 24 months, per quadrant or surgical site.
18. Periodontal maintenance after active therapy is covered two (2) times per calendar year.
19. Anesthesia requires a narrative of medical necessity be maintained in patient records. A maximum of 60 minutes of services are allowed for general anesthesia and intravenous or non-intravenous conscious sedation. General anesthesia is not covered with procedure codes D9230, D9241 or D9242. Intravenous conscious sedation is not covered with procedure codes D9220, D9221 or D9230. Non-intravenous conscious sedation is not covered with procedure codes D9220, D9221 or D9230. Analgesia (nitrous oxide) is not covered with procedure codes D9220, D9221, D9241 or D9242.
20. Orthodontics is only covered if medically necessary as determined by the plan. Patient copayments will apply to the routine orthodontic appliance portion of services only. Additional costs incurred will become the patient’s responsibility.